HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 20, NO. 12, ABSTRACTS 1655-1810. DECEMBER 1980

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HOSPITAL ABSTRACTS

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HOSPITALS IN GREAT BRITAIN

1655. HILL, Stanley. **Carrying their own cans.** *Health and Social Service Journal*, Basingstoke, 1980, Nov. 7, vol. 90, no. 4718, pp. 1444-1446.

The new profit-making Cromwell Hospital, London, is scheduled to open early in 1981, phased over about three months when all 128 beds are expected to be available. A second stage development about a year later will provide a whole body scanner, linear accelerator, simulator, high voltage therapy apparatus and treatment verification centre for cancer diagnosis and therapy. The hospital is designed, built and equipped to very high standards. The senior staff have already been appointed and this paper is based on interviews with them. In spite of having many ex-National Health Service staff, the management approach is rather different to that in the NHS. All staff stand on their own feet and make their individual contribution to profitability by working hard and avoiding waste. Despite the need to make a profit, the management is much more interested in patient care and more democratic and fair-minded towards staff than many hospital managements. It remains to be seen whether lower paid staff can be similarly motivated and whether adequate profit margins can be maintained in a highly competitive and extremely narrow and selective market.

1656. MILLER, Eric J. and NORRIS, Michael. **Planning processes for medical education and the health services in London.** *Lancet*, London, 1980, Oct. 18, vol. ii, pp. 846-849.

Following the publication of the Flowers report on London medical education and the London Health Planning Consortium's discussion document on a framework for acute hospital services in London, the Tavistock Institute for Human Relations was asked to undertake an independent study of the issues raised by these reports. The object was to determine whether it was possible to design and to test planning methods and mechanisms that would provide a sounder basis for decision making in the future. To establish whether this was feasible, a preliminary research phase was undertaken, using Westminster Hospital as case material but also looking at plans for London as a whole. This phase was in two parts: an institutional analysis of the hospital/medical school complex in the context of planning; and a critical review of current plannning methods and assumptions. In the light of these preliminary studies, it is believed that there is a serious risk that the decisions made will now lead to unforeseen (though not unforseeable) outcomes that may be undesirable in terms of effectiveness and the cost of service provision because: (i) the planning methods used have led to proposals which, in their own terms, are neither demonstrably relevant to existing needs nor clearly robust to changing circumstances; and (ii) insufficient account is taken of the nature of the social systems, including health services and medical school staffs as well as patients and students, which are being subjected to re-organization.

HOSPITALS IN OTHER COUNTRIES

1657. KOETTING, Michael. **Nursing-home organization and efficiency: profit versus non-profit.** Lexington, Mass., Lexington Books, 1980. x, 141 pp. ISBN 0 669 03290 5 £12.50

This investigation of the relative efficiency of profit and non-profit nursing homes in Illinois is in two parts: (i) a large sample statistical investigation was undertaken to test for differences among types of ownership and to select nursing homes for further investigation in the second stage of the study; and (ii) a detailed field investigation was made of particularly efficient and inefficient homes with different ownership to ascertain what, if any, specific managerial differences are associated with efficiency and ownership. The findings of the study include: (i) greater expenditure improves the likelihood of achieving high quality, but by no means guarantees it; (ii) non-profit homes are more likely to have higher quality than proprietary homes; and (iii) proprietary homes are more likely to achieve a given level of quality for less cost than non-profit homes.

1658. PICKERING, Errol and DUCKETT, Stephen. **The organization of hospitals in the People's Republic of China.** *World Hospitals*, London, 1980, Aug., vol. 16, no. 3, pp. 31-33.

This paper is based on a visit to four health facilities in January 1978: a 35-bed commune hospital serving a population of 60,000; a metropolitan neighbourhood health clinic in Peking serving 40,000 people; a 250-bed sanatorium for railway workers; and, principally, the Shin Hua Hospital, Shanghai, a 750-bed teaching hospital. The Chinese hospital system is based on an interlocking network of hospitals financed by the different levels of government, communes and some special agencies. There are three major types of schemes for paying hospital costs: (i) government workers and certain other groups receive insurance support from the State; (ii) each factory establishes a factory welfare fund into which workers pay a prescribed amount each month; and (iii) commune workers contribute to a 'co-operative medical scheme'. Like every major Chinese institution, hospitals are governed by a Communist Party committee comprising representatives of the various groups of staff. Each hospital department has a party branch. There is also a revolutionary (or management) committee, with sub-committees for: general office, education, administration, supply, propaganda, security and clinical affairs.

PLANNING, DESIGN AND CONSTRUCTION

DETERMINING SIZE OF HOSPITAL AND BED NEEDS

1659. FENNELL, Mary L. **The effects of environmental characteristics on the structure of hospital clusters.** *Administrative Science Quarterly*, Ithaca, N.Y., 1980, Sept., vol. 25, no. 3, pp. 485-510.

An organizational cluster is any set of two or more organizations of a common type located in the same geographical area. The hospitals within the boundaries of a Standard Metropolitan Statistical Area form a kind of local community of organizations.

This research was designed to explain three aspects of hospital cluster structure: (i) average size of hospitals within the clusters; (ii) range of services of the hospital cluster; and (iii) the degree of cluster differentiation. In the causal model that was developed and evaluated, variation in the patient environment and variation in the supplier environment were compared. Four lagged panels of data on a national sample of 15 hospital clusters demonstrated the relative superiority of supplier variables over patient variables. Supplier group preferences were more powerful than patient needs in determining the range of services offered by the cluster. Furthermore, increasing the range of services in the cluster had a positive, significant effect on average hospital size, whereas size apparently exerted no effect on range of cluster facilities. Cluster differentiation seems to be causally affected by range of services, average hospital size, and by the periodic closing of hospitals over time. A list of 82 references to the literature is included.

HOSPITAL DESIGN

See also Abstract No. 1687

1660. QUITMAN, Zobda and THOMAS, Paul. Un grand hôpital d'actifs aux Antilles: le nouvel hôpital de Fort-de-France. [**A large hospital for acute patients in the West Indies: the new hospital of Fort de France.**] *Techniques Hospitalières*, Paris, 1980, Aug./Sept., vol. 35, no. 419/420, pp. 33-36.

A new 750-bed acute hospital is under construction on a sloping 13-hectare site at Fort-de-France in the West Indies. The architects are Lebret, Treuil, Caillat and Meau. The T-shaped ward block has eight floors. Connected to it but further down the slope is one three-storey technical block, which has services for in-patients, including the operating suite, on the first floor, and the out-patient departments and X-ray department on the third floor which can be reached directly from the exterior. The second floor houses the services which are shared by the other two: laboratories, sterilization centre, pharmacy, functional exploration unit and computer centre. Solar heating will be used for the provision of hot water, and units which recover heat from the steam from the boilers and incinerator are also being installed. There will be a type of heat 'kitty' which ensures that the recovered energy is used to the best advantage. A medium-stay 500-bed hospital, a crèche and a school of nursing are to be built on the same site. This description contains a photograph of work in progress, a model of the acute hospital and a ground plan and exploded diagram.

1661. MORSS, Sherman. **Designing for hospital growth.** *Trustee*, Chicago, Ill., 1980, July, vol. 33, no. 7, pp. 41, 44.

This article describes a method of architectural planning to accommodate the unpredictable pattern of hospital growth. A modern hospital building must be both flexible and expandable. The Ambulatory Patient Center at Rhode Island Hospital, Providence, was built on a site that would not only make it accessible to other buildings in the complex but would enable growth when it was needed. This was achieved by good positioning and by placing mechanical shafts at the ends of the building. The Woodhull Medical and Mental Health Center, Brooklyn, New York, provides for the addition of new floors and the dividing up of large spaces. The methodology for this type of design is based on: (i) a deliberate overstatement of expansion for every

department; (ii) a network of open-ended corridors forming a circular skeleton; (iii) a zoning pattern along this skeleton providing separate areas for major hospital functions; and (iv) a deliberate effort to design simple, flexible space with fully co-ordinated mechanical systems.

1662. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Note on the relationship between planning health buildings and the cost of running them.** London, Department of Health and Social Security, 1980. [9]pp. bibliog.

There is no simple and direct relationship between the cost of building a hospital and the cost of running it, although methods are available, such as 'present worth' techniques, for striking a balance between the two. This note draws attention to some areas of planning which have a bearing on running costs: (i) the location of new buildings; (ii) the need for a good brief and carefully considered operational policies; (iii) the possibility of adapting existing buildings; (iv) the importance of good design and specification; and (v) the reduction of maintenance costs by careful detailing. A checklist of nine design considerations for engineers and architects is given. A list of references to the literature is provided, with summaries of selected items.

1663. STALDER, Felix. Humanität im Krankenhausbau. **[Humanity in hospital construction.]** *Krankenhaus-Umschau*, Kulmbach, 1980, Sept., vol. 49, no. 9, pp. 707-708.

Hospital designers were criticized by a working party which met in Hamburg in March 1979 to consider the topic of the 'more humane hospital' for failing, among other things, to provide partitions and proper communications equipment in patients' rooms, space for recreational activities, private conversations, overnight accommodation for members of the patient's family, and for inadequate directions and signposting. The author suggests that these failings are symptoms and not the cause of the lack of humanity in the hospital. He blames overcentralization, uniformity, buildings which are too big and lack of flexibility. He believes that the architect must think not in terms of systems, walls, ceilings and floors, but must have constantly before his eyes the spatial context of the patient's hospital experience.

EXTENSIONS AND RECONSTRUCTIONS

See also Abstract No. 1661

1664. SEBESTYEN, Victor. Möglichkeiten zur Sanierung und Modernisierung älterer Krankenhäuser. **[Possibilities of renovating and modernizing old hospitals.]** *Krankenhaus-Umschau*, Kulmbach, 1980, July, vol. 49, no. 7, pp. 569-571.

West Germany now has enough hospital beds and the author suggests that the task for the next few years should be to re-examine existing hospital stock and where necessary renovate and modernize older hospitals, i.e. those built in the 1950s and 1960s, to bring them up to present-day standards. Medical and technical advances and the increased emphasis on patient comfort demand this. He suggests that this examination should be carried out by an interdisciplinary team; they should look at:

(i) external and internal construction; (ii) functional efficiency; (iii) hospital equipment; (iv) hospital organization; (v) cost-effectiveness; (vi) the humanitarian side of care; and (vii) regional trends.

DESIGN OF SPECIAL HOSPITALS OR UNITS

1665. ROE, Alan. **Mental health buildings evaluation: Peterborough Development Project for Mentally Handicapped People. Report P1. Children's and adult's units at the Gloucester Centre.** London, Department of Health and Social Security, 1980. [ix], 109pp. (Mental Health Buildings Evaluation Report Series)

This report describes the buildings and services of the Gloucester Centre for mentally handicapped children and adults, near Peterborough. Subjects discussed include the characteristics of the residents, occupancy and staffing levels, siting, circulation, supervision, privacy, segregation, 'normalization' and flexibility. The physical performance of buildings is evaluated and cost information is provided. The report concludes that residential units should be smaller, with fewer residents, and that economy may result if children's and adults' units are of the same design. Seventeen plans are included.

ENGINEERING SERVICES

INSTALLATIONS IN GENERAL

1666. SKEGG, V. E. **The inter-relationship between engineering plant replacement and energy conservation.** *Hospital Engineering*, London, 1980, Oct., vol. 34, no. 8, pp. 3-14.

There are an increasing number of instances within the National Health Service where replacement of old inefficient boiler plant and/or the radical re-appraisal of thermal distribution systems have resulted in a dramatic reduction in fuel consumption. This paper presents brief case studies of 12 hospitals which have achieved savings by: replacing old steam boilers by modern economic installations; changing from central steam to central low pressure hot water (LPHW) systems; changing from centralized steam to decentralized LPHW; using hybrid systems in medium size acute hospitals; improving existing LPHW installations; and providing optimum start and external compensator controls. These case histories are illustrated by graphs. Additional hospitals where savings have been achieved are listed in tables.

COMMUNICATION SYSTEMS

1667. JONES, R. D. and others. **Microprocessor-based multi-patient environmental-control system for a spinal injuries unit.** *Medical and Biological Engineering and Computing*, Hitchin, 1980, Sept., vol. 18, no. 5, pp. 607-616.

This paper describes the multipatient environmental control system developed specifically for the new spinal injuries unit at Christchurch (N.Z.) Hospital. It has been designed around a modified standard communication system providing each patient

with the following facilities: nurse call, emergency nurse call, light, radio/television channel and volume and power outlets. All functions can be operated either directly from the bedhead panel and its handset controller or from one of a variety of possible single-switch tetraplegic inputs used in conjunction with an overhead scanning/selection display panel. Features of the system are: (i) interface systems catering for both acute and nonacute phases of the tetraplegic's hospital stay; (ii) facilities available at 14 bedheads on a plug-in basis resulting in ease and convenience of setting up of environmental control system facilities for patients; (iii) minimum of cords and external equipment resulting in a more hygienic and attractive environment; and (iv) central microprocessor control which has permitted the development of both optimal and flexible selection/control facilities for severely disabled patients. A preliminary evaluation after eight weeks' use is included.

HEATING

1668. CHUARD, Dominique and KLEIBER, Charles. L'utilisation de l'énergie solaire a l'hôpital du Pays-d'Enhaut. **[The use of solar energy in the hospital of the Pays-d'Enhaut.]** *Techniques Hospitalières*, Paris, 1980, Aug./Sept., vol. 35, no. 419/420, pp. 62-66.

The authors describe the solar energy system in the Pays-d'Enhaut Hospital at Chateau d'Oex. The south-facing balconies on the top floor are enclosed with glass, except in the summer, and this creates a greenhouse effect; the heat captured by the glass spreads through the patients' rooms. Thermostatic valves turn off the radiators there when the heat from the sun raises the room temperature sufficiently. In addition, there is a conventional system of solar captors on the hospital roof. The energy from these captors is used to heat water for domestic purposes, the swimming pools and the ventilation system. It is too early to say whether the system has fulfilled the designers' expectations. A cost-benefit analysis will be done at the end of this year. In addition to five photographs of the solar captors on the roof of the hospital, this article includes a diagram of the balcony-greenhouse, a section of the roof captors, three graphs illustrating energy stock management, a diagram of the solar energy system as a whole and block graphs showing energy consumption at different times of the year.

ENERGY CONSERVATION

See also Abstract No. 1666

1669. SKEGG, V. E. **When the bill is in millions.** *Health and Social Service Journal*, Basingstoke, 1980, Oct. 24, vol. 90, no. 4716, pp. 1385, 1387-1388.

Current energy economy measures are estimated to be saving the National Health Service £30 million a year. It is believed that at least another £30 million at today's prices can be saved without affecting direct patient care or general comfort levels in hospitals. Particular problems include: the age and variety of the buildings; and the wide variation in heating and lighting requirements. The steps being taken to reduce energy consumption are outlined. Emphasis is placed on the need for the active co-operation of all staff, both administrative and other disciplines, particularly in the use of electricity, if the amount and cost of energy is to be contained.

INSULATION AGAINST SOUND AND TEMPERATURE

1670. RATTUE, P. J. **Economic thickness of pipework insulation.** *Hospital Engineering*, London, 1980, Oct., vol. 34, no. 8, pp. 25-27.

A working group of Department of Health and Social Security and National Health Service engineers has been studying the economic thickness of insulation for hot and cold pipework (indoor and outdoor). They felt that the thicknesses should be calculated specifically for the hospital service, rather than adopt British Standard sizes, because hospital periods of operation per year tend to be greater than average; and that it would be useful to provide correction factors for further increases in energy and capital costs, and for various values of temperature difference and insulation conductivity. The study method is outlined and the results are presented in three parts; (i) indoor pipework for hot water and steam; (ii) indoor pipework for chilled water and refrigerants; and (iii) outdoor pipework generally.

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See Abstract No. 1672

PIPING INSTALLATIONS

See Abstract No. 1670

EQUIPMENT, FITTINGS, FURNITURE

INTERIOR DECORATION

1671. BECKER, Franklin D. and POE, Donald B. **The effects of user-generated design modifications in a general hospital.** *Journal of Nonverbal Behavior*, New York, 1980, vol. 4, no. 4, pp. 195-218.

This study, undertaken in one wing of a small general hospital, investigated the effects of minor modifications in design on: (i) the organization of the institution; and (ii) the reaction of various groups of users. All groups of hospital users were given the opportunity to help decide upon the design changes. Three medical/surgical nursing units were selected, one as an experimental area and two as control areas. Design changes occurred in the central corridor, the nurses' station and kitchen, the patients' lounge and the visitor's waiting area. Most changes were cosmetic and included fresh paint, murals, improved lighting and re-arrangement of furniture. A brief questionnaire was used for respondents to express their approval or disapproval of the innovations. Results showed that the changes had positive effects for patients and staff members on mood and morale and on the perceived quality of health care, but this was much less so for visitors. Variations in reaction among different groups are discussed. Use of social areas increased in the experimental ward, especially when visitors were present. Thus, by slight and inexpensive changes, the hospital can improve both staff morale and patient satisfaction.

MEDICAL EQUIPMENT

See also Abstract Nos. 1737, 1738

1672. Rosso, J. P. Les contrats de maintenance à l'hôpital: services biomédicaux. **[Maintenance contracts in hospital: biomedical services.]** *Techniques Hospitalières*, Paris, 1980, Aug./Sept., vol. 35, no. 419/420, pp. 39-43.

Four types of service contract are generally available for biomedical equipment: (i) preventive maintenance including a fixed number of annual visits, and with the replacement of defective parts being included in the charge; (ii) a contract covering periodic maintenance and breakdowns; (iii) an all-risks contract covering nearly everything except accessories and providing for a 24-hour service; and (iv) a mixed contract where the hospital is responsible for day-to-day maintenance and the supplier for major repairs. The most popular contract is the second, but type four is recommended for large items. Contracts generally run for one year and are renewable annually for five to eight years. The author presents a formula for calculating what the increase in the annual cost should be when inflation is taken into account. He also gives examples of the second type of contract for radiodiagnostic equipment, electronic monitoring units and laboratory apparatus, and one example of a type four contract for a scanner or linear accelerator. He emphasizes the need to choose equipment carefully in the first place and work out an approximate cost/service ratio before making any purchase.

1673. Rogers, R. T. **Advances in X-ray equipment design.** *Hospital Engineering*, London, 1980, Oct., vol. 34, no. 8, pp. 19-20, 22-25.

The medical equipment industry is very quick to incorporate advances in technology into the design of equipment, and in changing designs to cope with advances in medical techniques. The medical X-ray industry is no exception. This paper outlines some of the more recent advances in design, covering: generators; X-ray tubes; rare-earth screens and daylight film handling systems; processing and chemical mixers; image intensifiers and 100 mm 'photofluorography'; cassetteless large film systems; fluoroscopic tables; mobile X-ray units; equipment for special procedures; ultrasonics; and computer reporting. Possible future developments are discussed.

ELECTRONIC EQUIPMENT

See Abstract No. 1667

STAFF GENERALLY

RECRUITMENT

See Abstract No. 1680

STAFF MANAGEMENT

See Abstract Nos. 1681, 1685

STAFF TRAINING

See also Abstract Nos. 1656, 1676, 1677, 1682, 1683, 1730, 1768, 1801, 1809

1674. ANWAR, Rebecca A. H. **Trends in training: focus on emergency medicine.** *Annals of Emergency Medicine*, Lansing, Mich., 1980, Feb., vol. 9, no. 2, pp. 60-71.

In an attempt to identify factors affecting current issues regarding emergency medicine residency programmes, a research project was developed to study the process of professional socialization in graduate medical education by describing and analysing the development of emergency medicine residencies in comparison with those of surgery and internal medicine. Four principal data-gathering methods were used: interviews with residency directors; a longitudinal survey of residents; interviews with and observations of residents; and a longitudinal survey of emergency medicine graduates. These aimed to determine: the characteristics of the founders of the programmes: factors influencing physicians to enter a specialty; variations in residency programme organization and structure; and career patterns of physicians entering the specialty. The results are presented in tables and diagrams, and discussed. Implications are drawn from the data and applied to the development of residency training.

1675. BROOK, Peter. **Is psychiatric training improving?** *British Medical Journal*, London, 1980, Sept. 20, vol. 281, pp. 787-788.

All consultants in general psychiatry appointed to their posts between 1 October 1975 and 30 September 1978 were sent a questionnaire about their training experience in various aspects of psychiatric practice. The results showed that the standards of training in certain areas of psychiatry, including work in the community, subnormality and forensic psychiatry, were generally poor, although psychiatrists trained at the Maudsley Hospital or in teaching hospitals had a better overall training than those who had worked in psychiatric hospitals or general hospital psychiatric units. There has been an overall improvement in training since a survey made three years ago, but it was least pronounced in psychiatric hospitals. Approval visits made by both the Royal College of Psychiatrists and the Joint Committee of Higher Psychiatric Training would seem to be achieving results, but more attention needs to be paid to the training standards in psychiatric hospitals and units.

STAFF WELFARE

See Abstract No. 1684

SPECIAL CLASSES OF STAFF

MEDICAL STAFF

See also Abstract Nos. 1674, 1675, 1689, 1694, 1700, 1742, 1758, 1768

1676. **Guidelines for undergraduate education in emergency medicine.** *Annals of Emergency Medicine*, Lansing, Mich., 1980, April, vol. 9, no. 4, pp. 222-228.

These guidelines were developed following the completion of two surveys of medical schools' current courses in emergency medicine and an assessment of the core content

of the specialty at undergraduate level. In addition, medical schools with departments or sections of emergency medicine have contributed their sample curricula for review by the American College of Emergency Physicians. The guidelines cover two levels: basic and comprehensive. Components of the basic programme are: basic cardiac life support; and emergency medical services. The comprehensive programme covers: basic cardiac life support; introduction to emergency medicine; 40-hour emergency medicine lecture course; emergency medicine clerkship; and advanced cardiac life support.

1677. LATMAN, Neal S. and WOOLEY, Kenneth. **Knowledge and skill retention of emergency care attendants, EMT-As, and EMT-Ps.** *Annals of Emergency Medicine*, Lansing, Mich., 1980, April, vol. 9, no. 4, pp. 183-189.

A 4.1 per cent sample of all certified emergency care attendants (ECAs), emergency medical technicians (EMT-As) and paramedics (EMT-Ps) completed a multiple-choice questionnaire and a written test appropriate for their level of training. The purpose of the study was to measure retention of knowledge and skills. The average loss of didactic knowledge did not exceed 10 per cent over a two-year period. After two years the ECAs had lost approximately 55 per cent, EMT-As 50 per cent and EMT-Ps 61 per cent of their basic skills proficiency. Retention of knowledge and skill appeared to be directly related to frequency of use. Participants in continuing education programmes experienced an 11 per cent better retention average for skill than did non-participants. The staff of privately operated ambulance services retained their basic skills better than did members of other types of services. The rate of knowledge deterioration for the sample evaluated was not correlated to the original written score.

1678. DUFFY, David L., HAMERMAN, David and COHEN, Mary Ann. **Communication skills of house officers: a study in a medical clinic.** *Annals of Internal Medicine*, Philadelphia, Pa., 1980, Aug., vol. 93, no. 2, pp. 354-357.

The communication skills of house officers in the general medical clinic at Montefiore Hospital, New York, were studied. The clinic's medical faculty and liaison psychiatrist selected 10 communication skills that were observable and considered to be central to the doctor-patient relationship. Twenty interns and residents were observed in 60 clinic visits. The house officers most often demonstrated the skills relating to listening, history taking, assessing patient compliance, examining the patient and prescribing therapy. Underdeveloped skills were those that involved obtaining the patient's understanding of his illness, social history and emotional response, and the doctor's explanation of the illness. To enhance performance of these skills changes are recommended in four areas of teaching ambulatory care: liaison psychiatry, faculty development, medical precepting and the relationship between faculty and house officers.

NURSING STAFF

See also Abstract Nos. 1729, 1784

1679. CORMACK, Desmond F. S. **Obtaining access to data sources: an exploration of method, problems and possible solutions.** *Journal of Advanced Nursing*, Oxford, 1980, July, vol. 5, no. 4, pp. 357-370.

The difficulties encountered by nursing researchers in gaining access to research

data or respondents are outlined. In seeking permission to gather data from patients and staff in Scottish psychiatric hospitals, the author encountered the following problems: (i) the varying administrative levels to which the first formal request for entry had to be made; (ii) the varying routes which had to be followed in order to gain permission; and (iii) the time taken to obtain access to data sources. Two sets of recommendations are made which should minimize these difficulties. Recommendations to those who formulate policy are: (i) preparation of a written procedure to advise the researcher; (ii) identification of a single level of the management structure at which access may be granted or refused; and (iii) consideration of extension of local medical research and medical ethics committees to include nurses. Suggestions for researchers themselves are: (i) plan entry to research sites as far in advance as is possible; (ii) secure nursing permission for access before directing a request to non-nursing staff; (iii) when possible, give explicit assurances that nursing activity and patient care will not be disrupted; and (iv) enclose as much information as possible about the proposed data collection as is required to enable an informed decision regarding the request to be made.

1680. WINDSOR, Ralph and COLLINSON, Patricia. **Looking for tomorrow's nurses.** *Nursing Times*, Basingstoke, 1980, Oct., 16, vol. 76, no. 42, pp. 1849-1852.

Whatever the state of the employment market, nursing as a career has to be effectively presented if the quantity and quality of recruits to the profession are to be maintained. Recruitment advertising can be effective, but unless it is properly planned and monitored money may be wasted. This paper outlines the work behind the Department of Health and Social Security national recruitment campaign. The campaign consists of: advertisements in national magazines and newspapers; a wide range of leaflets; posters; films and video tapes; and exhibition units. Of these the biggest is advertising. Aspects of advertising discussed are: essentials of a successful advertisement; advertising strategy; creating an advertisement; and hitting the target. Some future developments are outlined.

1681. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. CENTRAL MANAGEMENT SERVICES. **Management services and the nurse: papers given at or prepared after a seminar held at the NHS Training and Studies Centre, Harrogate on 27-28 September 1979.** London, Department of Health and Social Security, Central Management Services, 1980. [iii], 42 pp. bibliog.

In this seminar for senior management services officers and nurses the papers and discussions were concerned with: the role and organization of management services; a computer-based learner nurse record system; the development and use of manpower planning models for nurse staffing problems; nurse staffing; the relationship of nursing needs, resources and standards in geriatric wards; dependency studies and the determination of staffing levels in obstetric and geriatric wards and in intensive therapy units; management services and the nurse: the need for collaboration; the nurses' view. A list of 24 references to the literature is included.

1682. CHAPMAN, Christine. **The learner as worker.** *Medical Teacher*, London, 1980, Sept./Oct., vol. 2, no. 5, pp. 241-244.

Nurses training for a statutory qualification in the United Kingdom (other than those on degree courses) are employees of the National Health Service (NHS). Unlike

their counterparts in the United States and Canada, they undergo an 'apprenticeship' type education. This might appear to be an ideal situation for learners, allowing good correlation of theory with practice, and for nurse tutors (who are also NHS employees) since it should give them easy access to learning situations. Unfortunately, this is not always so: ward teaching by qualified ward staff is frequently the latter's last priority, learners see their service commitment and the well-being of the patient as their primary concern, and nurse tutors may lack clinical expertise and credibility. The learner as worker is not an ideal situation and the combined management responsibility for service and education may produce more problems than it solves.

1683. DARWIN, Joan. **Nurse education: obedience is not enough.** *Nursing Mirror*, Haywards Heath, 1980, Oct. 2, vol. 151, no. 14, pp. 32-34.

A school of nursing should be able to list as its general objectives: (i) to help learners care for patients by preparing them for the practice of nursing with a detailed knowledge of nursing principles; (ii) to provide a basic foundation on which to develop specialized skills; and (iii) to help learners discover the public's expectation of its needs in the light of available resources. The training curriculum should be planned around each syllabus subject. Course objectives must consider the needs and interest of learners and should match the clinical experience available. The learning of nursing procedures and skills is often developed through observation. Teaching in the ward is a team activity and nurse tutors and ward sisters often underestimate the value of their experience. Practical work entrusted to a student nurse should be planned according to her training needs. The nursing process, a methodical approach to the planning and delivery of nursing care, is recommended by the General Nursing Council as a framework for teaching. The Nursing Division of the Department of Health and Social Security now has an adviser to help managers and teachers develop this type of planned nursing care.

1684. BACK PAIN ASSOCIATION. **Nurses and back pain: papers presented at a forum on back pain at the Area School of Nursing at the Derbyshire Royal Infirmary for nurse tutors.** Teddington, Back Pain Association, [1980]. 12 pp. (Ref. 500780) £1.00

A recent study indicated that 35 out of 1,000 nurses suffer back injuries each year. The papers given at this forum on back pain are concerned with: the size of the problem; training nurses in handling, with attention to the avoidance of low back pain; the applied anatomy, physiology and biomechanics of the spine; manual lifting; and mechanical aids and their role in the prevention of the occupational hazard of back pain. Five photographs of demonstrations given at the forum are included.

1685. PEMBREY, Susan E. M. **The ward sister: key to nursing; a study of the organization of individualised nursing.** London, Royal College of Nursing, 1980. 103pp. bibliog. (Research Series) ISBN 0 902606 61 1 £4.00

This study, which is based on observations and interviews carried out at five general hospitals associated with schools of nursing, was undertaken to develop measures of ward sister performance in relation to individualized nursing. Five aspects of the managerial role of 50 ward sisters were examined: (i) the nursing round of patients; (ii) written work prescription; (iii) verbal work perception; (iv) allocation of nurses; and (v) accountability reports. The study found that most of the sisters did not manage

the daily nursing on an individual patient basis; characteristics of the two groups of sisters thus distinguished by their managerial approach are identified and discussed.

OTHER PROFESSIONAL AND TECHNICAL STAFF

See also Abstract No. 1730

1686. GOLDFRANK, Lewis, CORSO, Thomas and SQUILLACOTE, David. **The emergency services physician assistant: results of two years' experience.** *Annals of Emergency Medicine*, Lansing, Mich., 1980, Feb., vol. 9, no. 2, pp. 96-99.

The physician assistant (PA) has become an integral part of urban health care. The roles chosen are diverse and often meet the particular needs of physicians or hospitals. A unique programme for the training and development of PAs in emergency services has been developed in two distinctly different hospital settings: Montefiore Hospital and Medical Center and North Central Bronx Hospital, New York. Their training and duties are outlined. The PA has replaced the junior house officer or medical student in the emergency medical service surgical sphere. While 'minor' assessments had previously been the responsibility of the uninitiated, the PA now emphasizes techniques, limits service variability and helps to stabilize a service previously in a state of flux. In addition, the PA has emphasized preventive care. It is considered that the PAs can significantly improve the quality and quantity of care rendered.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 1655, 1658, 1796, 1797

1687. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Nucleus hospitals: whole hospital policies.** London, Department of Health and Social Security, 1980. ii, 25pp.

This manual brings together policies for a number of whole hospital functions, together with a guide to relevant legislation affecting design and operation. It is designed to be used in conjunction with guidance already issued on Nucleus design hospitals, in particular the departmental planning principles and design descriptions, and will also be supplemented by a companion volume dealing with project strategy. The functions covered are: (i) administration; (ii) facilities for staff; (iii) catering; (iv) domestic services; and (v) supply and disposal.

1688. LACHÈZE-PASQUET, P. Organiser les hôpitaux. **[Organizing hospitals.]** *Techniques Hospitalières*, Paris, 1980, Aug./Sept., vol. 35, no. 419/420, pp. 71-73.

The author holds that at a time when expenditure is being cut back wholesale, the presence of an organization and methods unit in each regional hospital becomes more essential than ever. He supports his contention with a brief account of the savings achieved by reorganization of administrative services in one hospital, of the invoicing department in another and of internal transport in a third, and with a study of the running of the main departments in a fourth. In all, savings of 920,000 francs annually were achieved as a result.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract No. 1657

1689. DRUMMOND, Mike and YATES, John. **Will you achieve more than your predecessor? Evaluating effectiveness and efficiency in the hospital service.** Manchester, University of Manchester, Department of Social Administration, Health Services Management Unit, 1980. [i], 34pp. (Working Paper No. 30) £2.00

This paper stresses the importance which should be attached to the evaluation by hospital physicians of clinical treatment, and is largely concerned with the methodology of such evaluation. Examples are given of evaluation undertaken in response to immediate, locally perceived problems, where differences in practive within a hospital, between hospitals and between medical specialties are examined. This is contrasted with a wider-ranging cost-benefit approach in which two types are distinguished: (i) cost effectiveness analysis, with examples including a comparison of in-patient surgery with injection-compression sclerotherapy for the treatment of varicose veins; and (ii) cost benefit analysis, with examples including a comparison of domiciliary and institutional care for the elderly. A list of 34 references to the literature is included.

RUNNING COSTS

See also Abstract Nos. 1662, 1669

1690. BILES, Brian, SCHRAMM, Carl J. and ATKINSON, J. Graham. **Hospital cost inflation under state rate-setting programs.** *New England Journal of Medicine*, Boston, Mass., 1980, Sept. 18, vol. 303, no. 12, pp. 664-668.

To determine whether hospital cost containment in the United States has been helped by state intervention, a comparison was made between six states with comprehensive, legally mandated hospital rate-setting schemes and 44 states without such schemes during the period 1970 to 1978. The six states were Connecticut, Maryland, Massachusetts, New Jersey, New York and Washington. Community hospitals were used to represent the type of hospital generally subject to state regulation and data were drawn from the American Hospital Association's *Hospital Statistics*. Cost per admission was chosen as the best indicator by which to compare the rate of increase in hospital costs in the two types of state. The study revealed an annual rate of increase in hospital costs in rate-setting states of 11.2 per cent as compared with 14.3 per cent in states without rate-setting during the years 1976 to 1978. These data uphold the view that rate-setting schemes which establish rates prospectively and which cover most patients can effectively contain increases in hospital costs.

1691. CUNNINGHAM, Robert M. **VE has made a good beginning.** *Trustee*, Chicago, Ill., 1980, July, vol. 33, no. 7, pp. 23-24, 26.

The American voluntary health care cost containment effort (VE), organized in 1977 to meet the threat of mandatory control on hospital costs, now includes insurance and business groups as well as hospitals and medical organizations. Much has been achieved and the common cause of saving money has lessened the tension between doctors and hospital administrators. As the potential for cost reduction through efficiency is exhausted, the effort to control use intensifies. This can only be achieved by a combination of governing authority, management skill and medical judgement. The VE

has demonstrated that it is a potential vehicle for achieving rational use of needed services, but there is a long way to go before the future of voluntary initiative is made secure.

1692. SANDERS, Charles A. **Rate-setting in hospitals—the beginning or the end?** *New England Journal of Medicine*, Boston, Mass., 1980, Sept. 18, vol. 303, no. 12, pp. 697-699.

Rising hospital costs in the United States are caused by: (i) Medicare, Medicaid and other health insurance schemes; and (ii) the growth of medical technology in the diagnosis and treatment of disease. National efforts to reduce the rate of increase in costs have been only moderately successful and now individual states are taking the initiative. Another study in this journal has shown that the rate of increase has been reduced in six states by the introduction of rate-setting schemes (see Abstract No. 1690). However, there are several problems in comparing the performance of the rate-setting states as there are many differences between them, including: (i) the number and type of hospitals: (ii) the method of payment; and (iii) whether the relationship between the rate-setting commission and the hospitals is co-operative or antagonistic. The schemes do not provide any incentive to save, nor do they allow for any innovation in the system of health care delivery. Regulation alone cannot provide a long term solution to the problem of increasing hospital costs.

1693. RESTUCCIA, Joseph D. and MURPHY, Daniel V. **Estimating hospital costs by diagnosis group.** *Inquiry*, Glenview, Ill., 1980, vol. 17, no. 2, pp. 155-164.

This paper provides a general methodology that may be used by regional planning and review bodies in the United States to help providers of health care monitor hospital costs and use. The method uses information collected as part of the Uniform Hospital Discharge Data Set. The analysis described measures hospital use and costs by diagnostic groups for acute in-patient services in nine hospitals in Michigan during 1976. Three variables were examined in analysing expenditures: (i) the hospital discharge rate for patients with a certain diagnosis; (ii) the relative length of stay for that diagnosis; and (iii) the intensity with which hospital services were used during treatment for the particular illness. Heart disease accounted for 11.7 per cent of total acute in-patient expenditures, fractures and other trauma for 9.1 per cent and cancer for 8.3 per cent. All these diagnoses had a higher than average cost per admission owing to longer periods of stay and/or higher costs per patient day. Thus, the cost ratio for a given diagnosis can be expressed in terms both of the daily cost ratio and the length of stay, relative to the average length of stay across all diagnoses. Estimates of cost by diagnosis can be used to assess the relative importance of various disease categories for a population served by a particular group of hospitals. The identification of a wide variation in hospital expenditures is an important aid in selecting schemes aimed at reducing hospital costs.

BED OCCUPANCY, ECONOMIC USE OF BEDS

1694. MCEWAN, Duncan. **Physicians can treat cost control ills.** *Health Care*, Don Mills, Ont., 1980, Aug., vol. 22, no. 8, pp. 31, 35-38.

Doctors in Canada are beginning to realize that they have a part to play in containing health service costs. The doctor makes the most demands on resource allocation

and utilization review in the hospital should be extended to involve all medical services. There are three clinical decisions that need to be monitored: (i) admission to hospital; (ii) length of stay; and (iii) use of medical support services for diagnostic and therapeutic purposes. The application of utilization review can be simple or sophisticated according to the need, size and operation of the hospital and it may be current or retrospective. Planning the utilization review can be done by collaboration between management and medical staff. Utilization review can help management achieve increased efficiency and can give medical staff support in decision-making, thereby reducing their need to practise defensive medicine. While the planning and operation of review procedures in hospitals should be at a local level, the government has a part to play by financing the procedure in selected hospitals and rewarding the hospital when efficiency is improved.

1695. MACSTRAVIC, Robin E. and FIELD, Nancy. **Why occupancy isn't the best measure of hospital performance.** *Trustee*, Chicago, Ill., 1980, Aug., vol. 33, no. 8, pp. 33-36.

Occupancy is a time-honoured measure of hospital efficiency and bed need, but it is a measure whose chief virtue is its ease of calculation. This paper questions: the accuracy of occupancy figures; what they tell us about the efficiency of a hospital; how appropriate they are in determining bed needs; and whether there are better measures than occupancy of a bed's capacity and use. It is concluded that specific indicators of cost, quality and access are far more accurate and important measures of the appropriateness of a hospital's capacity and use. They are, however, more difficult to develop and interpret.

APPOINTMENT SYSTEMS, WAITING LISTS

1696. BUTTERY, Roger B. and SNAITH, Alan H. **Surgical provision, waiting times and waiting lists.** *Health Trends*, London, 1980, Aug., vol. 12, no. 3, pp. 57-61.

Hospital Activity Analysis figures for 1977 for the English health regions are analysed for each of six specialties: general surgery; ear, nose and throat; orthopaedics; ophthalmology; urology; and gynaecology. These account for 90.8 per cent of all surgical discharges and deaths. The main findings of the analysis are: (i) regional differences in the numbers of surgeons, numbers of operations per surgeon and numbers of operations per 100,000 population are considerably greater than differences in financial allocations; (ii) waiting lists are not correlated with surgical provision; and (iii) waiting times for operations are relatively constant whatever the level of provision. A method is proposed for estimating what the number of operations should be in each region according to its income.

OFFICE MANAGEMENT AND METHODS

See Abstract No. 1765

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 1704, 1715, 1717, 1762, 1765, 1769, 1770

1697. NORTHCUTT, Douglas B. **New hospital system option: distributed data.** *Hospitals*, Chicago, Ill., 1980, Aug. 16, vol. 54, no. 16, pp. 123-124, 126.

Hospitals requiring more integrated and more comprehensive information systems

have previously had the option of choosing between two computer alternatives—centralized or decentralized systems. A third alternative—distributed data processing—is now available. In this approach, a data processing network is formed by minicomputer systems that operate either independently of or interactively with other processors through interface with a central processor. Each minicomputer manages its own database, performs processing functions for data collection and distributes data by communicating with the large central processor. The system must meet requirements in the following areas: financial control and accounting; data collection and patient history database; and patient care support. Although more complex than other systems, the distributed system is more economical because it requires less expensive hardware. Alternative distributed system designs are: centralized or star network; hierarchical or tree network; and independent or fully connected network. The planning, management and control of a distributed system are discussed.

1698. BERNEY, J. Ph., BAUD, R. and SCHERRER, J. R. **Towards the use of a tree branching logic in the environment of a hospital information system.** *Methods of Information in Medicine*, Stuttgart, 1980, Oct., vol. 19, no. 4, pp. 187-194.

The DIOGENE project at the University Hospital, Geneva, forms the basis of a growing hospital information system. A Frame Selection System (FSS) has been designed to make the computer system easier for physicians, nurses and clerks to use. A formal algorithm for the definition of a FSS for handling dialogue between the user and the computer is described here. It is shown how natural medical language can be handled using a tree branching logic. This logic is based upon ordered series of selections which enclose a syntactic structure. The FSS is an interaction between a page library and an executive program operated by the user at the terminal. The external specifications of the system are discussed with regard to convenience and efficiency. As the FSS software governs the communication between the user and the application programs, messages can be assumed to be free from syntax error. FSS helps to achieve consistency and stability in a transaction-orientated system with large data bases and concurrent points of access.

1699. LUND, Brian. **A PET computer of your own.** *Health and Social Service Journal*, Basingstoke, 1980, Sept. 19, vol. 90, no. 4711, pp. 1227-1229.

Initial consideration of a computer system for the medical records department of the 1,000-bed North Tees General Hospital envisaged a major installation to serve the overall needs of the medical records service. As the necessary capital investment was not available, a PET computer was eventually purchased to provide a limited system. The cost for a visual display unit, 400K disc storage unit, bi-directional printer discs and software was £3,700. The first operation was to document patients and produce identification labels. The program also includes: production of bed states; overall nominal roll of in-patients; list of patients in religious grouping; daily list of admissions/discharges by general practice; daily ward activity analysis summary; specialty analysis; lists of admissions, discharges and day cases; list of patients of pensionable age; and area of residence. The only problem has been access, the VDU being the only input medium. The minicomputer was quickly accepted by staff following detailed explanations and demonstrations.

1700. McDonald, Clement J., Wilson, Gregory A. and McCabe, George P. **Physician response to computer reminders.** *Journal of the American Medical Association*, Chicago, Ill., 1980, Oct. 3, vol. 244, no. 14, pp. 1579-1581.

The computerized medical information system used at Wishard Memorial Hospital, Indianapolis, since 1973 contains results of most diagnostic studies and records of medication use for most general medicine clinic out-patients. At each visit, the computer provides a tailored encounter form and a flow sheet summary of each patient's medical history and follows medical staff management rules to remind the physician about patient conditions requiring his attention. The report containing these reminders is called the 'surveillance' report. In a 15-week study involving nine internal medicine interns, 17 internal medicine residents and five nurse-practitioners, it was found that the reminders significantly increased the clinician response rate (in terms of test orders and treatment changes) to the events in question. The addition of relevant medical literature citations to the reminders did not significantly change the clinician response rate as compared with reminders alone, nor did it stimulate the physicians to read any of the cited articles kept in an immediately available 'library' of reprints.

1701. Hancox, A. J. and Moore, A. J. **The design and development of a computerised I.T.U. planned preventive maintenance system.** *International Journal of Bio-Medical Computing*, Limerick, 1980, Sept., vol. 11, no. 5, pp. 357-378.

A planned preventive maintenance (PPM) system is essential in an intensive therapy unit (ITU) if the equipment is to be kept at peak efficiency and an adequate return on the high capital outlay is to be achieved. In order to reduce the administrative burden placed on technical staff a computerized PPM system has been developed for the ITU at Dudley Road Hospital, Birmingham. The development of the system from manual and semi-automatic systems is outlined, The system is based on MUMPS-11. Aspects of the system operation described are: file structure; phasing in and out of equipment; input/output; and organization of work load. The system has been shown to: eliminate many communication problems; make statistical analyses less time-consuming; rationalize phasing in and out of equipment; contribute to job satisfaction of technicians; and reduce average breakdown time per machine per month. Although used for an ITU, the package could be used in any environment where PPM takes place and its possible application to the Estmancode system used by works departments is discussed.

INFORMATION SYSTEMS

See Abstract No. 1698

ORGANIZATION AND METHODS, WORK STUDY

See also Abstract Nos. 1688, 1761

1702. Pasteur, P. and Viossat, M. La théorie des systèmes comme approche globale de l'hôpital. **[Systems theory as a total approach to the hospital.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1980, Aug./Sept., no. 198, pp. 671-680.

A system may be defined as a 'set of interacting elements, the activity of which is

directed towards a goal'. The authors propose that the hospital is a system because it has three main components (patient care, administration and general services) and its goals are the distribution of care and diagnostic activity. The three components are unequal in size and in the proportion of skilled staff in each, since the proportion of skilled staff is greater in care activities than in the administrative and general services. But these three components are united by relationships and interactions. The inputs to the system, and the outputs, are the patients. The authors go on to show that the hospital is an open socio-technical system, supporting this view with a series of eleven reasons. Because it is an open socio-technical system, working conditions are affected. Because care is of primary importance, the administrative and general services components generally lack prestige; this may account for employees' lack of motivation and attention to work. The less skilled workers are also more at risk from accidents. Another effect of the differentiation of functions is conflict between doctors and administrators, particularly at a time when the authorities are trying to control hospital expenditure. Nurses have to spend a great deal of their time negotiating compromises between doctors and administrators.

1703. LUSK, Edward J. **A suggested process for selecting a forecasting model.** *Hospital and Health Services Administration*, Chicago, Ill., 1980, vol. 25, special issue 1, pp. 23-37.

There are three variables which must be considered in selecting a forecasting model for use in short-term planning and control: the nature of the activity to be predicted; the required accuracy of the forecasts; and the cost. Since these variables are interrelated for particular models, they are discussed for the following classes of forecasting models: cognitive, proportional change, regression, time series and econometric. Most of the activity in health service institutions may be characterized as being generated from a complex but regular process. When this is the case, the proportional change model is capable of generating forecasts which are comparable in accuracy to forecasts generated by centered moving average and autoregressive integrated moving average models. This is demonstrated using three cases: weekly patient activity; daily patient activity; and daily emergency room encounters per eight-hour shift. The proportional change model is likely to provide management with reasonable forecasts with little institutional effort; in those situations where it fails, alternative forecsting models may be developed.

MEDICAL RECORDS

See also Abstract Nos. 1699, 1700, 1771, 1778

1704. GELL, G. Medizinische Befunddokumentation durch Klartextanalyse. **[Documentation of medical findings with free-text analysis.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1980, June, vol. 21, no. 6, pp. 351-352.

This is a short account of the use of the AURA free-text documentation system for preparing reports in the radiology, pathology and cytology departments where all the information comes in a relatively compact and standardized form. The doctor first indicates his findings; these are then printed on to a video display unit, where they also

appear in the form of a normal doctor's letter. The data can be stored on magnetic tape. This system has been in routine use in Graz Hospital for 10 years. As well as serving its main purpose of data storage and retrieval, the system enables users to carry out computerized cross-checks of interclinical radiological and pathological data.

1705. UNITED STATES. NATIONAL ACADEMY OF SCIENCES. INSTITUTE OF MEDICINE. DIVISION OF HEALTH CARE SERVICES. **Reliability of national hospital discharge survey data: report of a study.** Washington, National Academy of Sciences, 1980. viii, 156pp. (I0M 80-02) ISBN 0 309 03079 £4.90

This report assesses the reliability of data collected as part of the National Hospital Discharge Survey (NHDS) carried out by the National Center for Health Statistics. Information for the NHDS is abstracted primarily from the face sheets of patients' medical records by hospital staff or by the Bureau of the Census. The analysis, involving re-abstracting of a sample of medical records included the NHDS in 1977, showed that non-medical details about patients were generally accurate, but that reliability of the medical data items varied considerably, depending on the diagnostic classification and coding schemes that formed the basis of comparison. These findings agree with two previous studies of hospital discharge data by the Institute of Medicine. Recommendations for improvements are made specific to the NHDS and related to hospital discharge data collection generally.

1706. ROTH, Loren H., WOLFORD, Jack and MEISEL, Alan. **Patient access to records: tonic or toxin?** *American Journal of Psychiatry*, Washington, D.C., 1980, May, vol. 137, no. 5, pp. 592-596.

In August 1975 Western Psychiatric Institute and Clinic, a teaching hospital of the University of Pittsburgh, formulated a new policy allowing a patient access to his or her medical record unless such access would be detrimental to the patient's well-being. Access would not be allowed to sections of the medical record which may invade the privacy of any third party. Patients are permitted to read the record with a staff member present to explain the information in it. Copies of the records are not provided. In a 1½-year study period, there were 16 requests to see records; 12 people (one the father of a deceased ex-patient) were eventually interviewed by the medical director and/or another author of this paper. Eight persons were afforded access to the record, two were denied access to selected portions of the record, and two were denied any access. Although the number of patients interviewed was small, certain themes were evident: (i) all the patients except two were pleased with the opportunity afforded them; (ii) the patients were satisfied that the record was a fairly accurate description of their behaviour as they remembered it; and (iii) patients had some concern about the meaning of the diagnoses given. Seven case examples are given. This limited patient access to records has resulted in a generally positive experience for the patients, and no harm has ensued.

HOSPITAL STATISTICS

See Abstract No. 1705

LEGAL AND ETHICAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 1706, 1737, 1804

1707. GRAY, J. A. Muir. **'Section 47': an ethical dilemma for doctors.** *Health Trends*, London, 1980, Aug., vol. 12, no. 3, pp. 72-74.

Section 47 of the National Assistance Act 1948 provides for the compulsory removal to a hospital or old people's home of people who are suffering from a grave chronic disease or who, being aged, infirm or physically incapacitated, are living in insanitary conditions and are unable to devote to themselves, and are not receiving from other persons, proper care and attention. The origin of these powers are outlined. Replies to a questionnaire from 168 community physicians in England showed that 830 people were compulsorily removed, mainly to hospital, in the four years 1974-75 to 1977-78. There seems to be little criticism of the operation of Section 47, but there is no set of universally agreed criteria for intervention and opinions on some cases might differ. The author does not think the Section should be repealed, but it does require amendment in several respects: (i) alteration of the criteria used; (ii) involvement of a social worker; (iii) suitability of the community physician as the responsible officer; (iv) changes in the nature of the order; and (v) use of the powers should be monitored.

1708. BROWN, Bernard L. **Risk management for hospitals: a practical approach.** Germantown, Md., Aspen Systems Corporation, 1979. xviii, 187pp. bibliog. ISBN 0 89443 090 4 £14.75

The increase in malpractice claims against hospitals in the United States and the related rise in professional liability insurance payments have led to growing interest in risk management programmes, which seek to prevent any incidents resulting in financial liability to hospitals. This book is a guide to the planning, organization and implementing of such a programme, and also includes a section on self-insurance. The subjects covered include: environment control and energy conservation; fire safety; staff safety; patient and public safety; disaster; education; security; and infection control. Checklists are provided as practical aids to developing a risk management programme, and nine references to the literature are included.

OTHER SPECIAL ASPECTS

1709. WEAVER, N. D. H. **National and political aspects of closures: can we manage things better?** *Hospital and Health Services Review*, London, 1980, Oct., vol. 76, no. 10, pp. 338-339.

There is in any public service a tension inherent between needs as seen by the service and as seen by the public. In relation to hospital closures, the procedure, in most cases, requires the Secretary of State's approval. There is considerable dissatisfaction among administrators with the mechanism and a feeling that a system needs to be devised that excludes the political veto. But closures are a matter for final political decision. Relatively few closures are opposed by community health councils, so the issue appears to be how to improve upon present arrangements rather than make radical

alterations. The aim might be to ensure: (i) rational debate in public and by the public; (ii) creation of a forum independent of the health structure to reach a conclusion; (iii) speedy processing to minimize planning blight, staff and patient anxieties, and achieve the intended economies as soon as possible; and (iv) swift ministerial decision. A health service procedure could be based on review boards covering three or more regions and serviced by the Department of Health and Social Security or, better still, functioning independently. Each board would have technical assessors. A possible time scale in the region of 16 to 17 weeks is suggested.

1710. CHARLES-EDWARDS, David. **Commissioning in Oxford.** *Health and Social Service Journal*, Basingstoke, 1980, Oct., 3, vol. 90, no. 4713, pp. 1286-1289.

In July 1980 the closure of Cowley Road Hospital marked the completion of the biggest organizational change in Oxford's hospitals since the Radcliffe Infirmary in 1770. The John Radcliffe Hospital which opened in July 1979 was the focal point of these changes. In this paper the personnel officer of Oxford Area Health Authority describes his work as a member of the commissioning team. The main personnel task, called staff transfer, involved providing 3,000 staff for the John Radcliffe Hospital site and transferring several hundred more to new locations elsewhere in central Oxford. This was accomplished in two distinct though overlapping stages: deciding staffing levels and establishments; and individual transfer. The determination of staffing levels went through several stages: manpower information; negotiation with management; and consultation and negotiation with the trade unions. A key to the whole exercise was effective communication. Despite many problems, the hospital opened on time.

1711. WENDT, Diana G. **Anatomy of a merger.** *Trustee*, Chicago, Ill., 1980, July, vol. 33, no. 7, pp. 35-36, 38.

The New York Infirmary and the Beckman Downtown Hospital have merged to become the first full-service hospital in lower Manhattan. They plan to combine physically in 1983. Once the board chairmen and their chief executives had approved the merger idea, it was presented by the executive committees to their boards and a financial feasibility study was carried out. Medical staff and the community viewed the proposed merger as a better allocation of resources. A merger committee carried out the negotiations with the support of government regulatory agencies. A new board was elected which in turn elected its chairman, the administrative head and the medical board. The two medical staffs have been joined under the new medical board and the integration of administrative departments is under way. A unified prospective reimbursement rate gives the new hospital a firm financial basis for the future.

1712. FRIEDMAN, Laurence A. and others. **A computer simulation model of hospital mergers.** *Health Care Management Review*, Gaithersburg, Md., 1980, vol. 5, no. 3, pp. 53-65.

One of the primary motivations for hospital mergers is the desire to control or moderate the accelerating increases in hospital costs. This paper reports a study to predict the costs of a potential merger of three hospitals. The study relied on a statistically based cost-prediction model that was adapted to reflect several different merger options or scenarios. The future costs of the three unmerged hospitals were simulated

using a stochastic simulation model. The three merger options were: (i) no sharing; (ii) joint use or sharing of all feasible ancillary departments; and (iii) joint use or sharing of selected departments. Option (ii) showed average annual cost savings ranging from nine to 35 per cent under different assumptions regarding changes in cost structure of the merged hospitals. For option (iii) the savings ranged from 2.9 to 6.6 per cent.

FINANCE AND ACCOUNTING

FINANCE

See also Abstract No. 1708

1713. GARDNER, Everette S. and MCLAUGHLIN, Curtis P. **Forecasting: a cost control tool for health care managers.** *Health Care Management Review*, Gaithersburg, Md., 1980, vol. 5, no. 3, pp. 31-38.

The relationship between demand and cost is discussed briefly. Control of costs is closely related to the ability of administrators to predict the demand for services over the short run. The central issue in forecasting is that of deciding how to use the data available in the organization to make predictions that are as accurate as is economically practicable. Various approaches to forecasting are outlined. A growing and highly variable demand for its services led the clinical coagulation laboratory of the North Carolina Memorial Hospital, Chapel Hill, to evaluate 25 models using four methods of forecasting: (i) linear regression with or without seasonal factors; (ii) exponential smoothing models on raw data; (iii) exponential smoothing models on deseasonalized data; and (iv) 'Box-Jenkins' models. The method of evaluation was the mean squared error. The results are summarized in a table. It is recommended that in selecting a forecasting technique, the criteria should be: the one that best fits the data; staff sophistication; and finance. Simplicity is often a virtue in the forecasting business.

1714. CLÉMENT, Jean-Marie. Les investissements hospitaliers: programmation financement analyse critique. **[Capital investment by hospitals: planning, finance, analysis.]** *Revue Hospitalière de France*, Paris, 1980, Oct., vol. 44, no. 334, pp. 953-958.

At a time when the French Ministry of Health has refused permission for any capital investment of over one million francs which generates an increase in operating costs of more than five per cent and does not lead to a reduction of ten per cent of the beds involved by the project, the author emphasizes the need to programme capital investment. He equates planning with strategy and programming with tactics and defines the latter as the anticipation of requirements, the achievement of wide agreement on objectives, increased efficiency of decision-making and wide consultation inside and outside the hospital. He examines possible sources of finance for capital investment: (i) internal depreciation funds; and (ii) external financing: interest-free loans from Government, social security funds or local authorities, and loans at market rates from banks, local authorities or insurance funds. Interest-free loans are no longer easy to obtain and there are often long delays before the promised amounts arrive. The hospitals have proposed that there should be a central investment fund or else an

investment fund in each hospital, called the replacement reserve. So far the Government has ignored these proposals. The author believes that public hospitals should have more financial autonomy and considers that it is a mistake to freeze capital investment.

COSTS

See Abstract Nos. 1718, 1757, 1787

HOSPITAL ACCOUNTING

1715. RASCHEN, Gebhard and VETTER, Volkhardt. FINK, KOLK, MAIK: ein Erfahrungsbericht über die Einführung von ADV-Verfahren des Rechnungswesens in den kommunalen Krandenhäusern Bremens. **[FINK, KOLK, MAIK: an account of an experience with the introduction of computer-aided processing of the accounts of the local authority hospitals in Bremen.]** *Krankenhaus-Umschau*, Kulmbach, 1980, Aug., vol. 49, no. 8, pp. 651-654.

This is a description of the introduction of centralized computer processing of the accounts in six local authority hospitals in Bremen, which between them have 5,300 beds and about 5,400 employees. The hospitals are linked by means of a sub-system to the Local Authority Accounts Centre. Each of the five smaller hospitals has one video-terminal and a printer, while the largest hospital (1,900-bed Central Hospital) has four terminals. Three programs are used: FINK (mechanized hospital financial accounts), KOLK (cost-effective accounts) and MAIK (equipment accounts). The project took much longer to bring into operation than expected because of human and mechanical errors. However, it is now working smoothly and is proving to be cost-effective. It is hoped to introduce KREK (creditor accounts) and MARK (materials management accounts) programs in the near future.

1716. FINKLER, Steven A. **Cost finding for high-technology, high-cost services: current practice and a possible alternative.** *Health Care Management Review*, Gaithersburg, Md., 1980, vol. 5, no. 3, pp. 17-29.

The principal form of cost-finding in hospitals is a 'horizontal' system, in which the primary focus is on departmental costs. This was efficient until hospital costs began to rise rapidly and continuously. Although hospitals know the costs of individual departments, they do not readily know the total cost impact of offering a specific, high-cost, high-technology service. In contrast, a 'vertical' cost-finding system, common in industry, is oriented toward the cost of the final products or outputs. The two systems are compared. The use of vertical cost-finding for calculating the cost of introducing a new programme or a specialized selective service is described. Open-heart surgery is used as an example. Steps in the system are: (i) determining the exact production process for the service in the form of a flowchart; (ii) identification of input factors; (iii) resolving conceptual issues; and (iv) data accumulation using a series of worksheets, which are reproduced. It is contended that hospital administrators need a more vertically or programme-oriented cost system than that currently in use if they are to meet the

demands of health systems agencies and to make cost-effective decisions regarding whether it is socially desirable to offer a programme.

SUPPLIES AND STORES

STORES

1717. BONHOMME, C. Les possibilités de la mini-informatique: essai d'application a la comptabilité des stocks. **[The possibilities of mini-computerization: trial of application to stock accounting.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1980, Aug./Sept., no. 198, pp. 683-687.

The national computer systems used in many large French hospitals are not always suitable for smaller establishments: they lack flexibility, and their results and presentation are standardized. The author proposes that a mini-computer system might be used for stock accounting only. He calculates that, for a stock of 2,500 different articles, a system which would permit storage of about two million characters is required. Double-sided, double density floppy disc systems are now available for this purpose. The more advanced mini-computer models operate sequentially and can re-group information scattered over several files. Thay have an alphanumerical keyboard, allowing acquisition and checking of the data, a control screen, a floppy disc unit and a printer. The author advises that a consultant be employed to produce a turn-key system comprising the equipment and the special soft-ware required. He lists the basic files which have to be compiled: articles, suppliers, user departments, stock accounts and stock accounts per department, and describes working procedures.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

1718. BELL, Arthur G. **How to improve meals while cutting costs.** *Health Care*, Don Mills, Ont., 1980, Aug., vol. 22, no. 8, pp. 32-34.

The new food service system at York Central Hospital, Richmond Hill, Ontario, has reduced staff numbers and produced savings of over $100,000 per year. A cook and chill production system was introduced in 1979 with a 14-day menu cycle. A complete set of menus was produced to meet the requirements of a chilled food system. The ingredient control centre weighs, measures and portions all items for the cooks. Food production is carried out in a five day week, providing greater flexibility in hours and reducing staff from 54 full-time equivalents to 43 full-time employees. An integral heating and tray cart system was introduced in May 1980. Ready-portioned food is placed in special carts and refrigerated. When needed, the carts are plugged into special circuits which heat each hot food dish to serving temperature while cold food remains cold. The food reaches the patient hot and without loss in nutritional value. When the new food system was introduced, certain improvements in the quality of food purchased were also made.

1719. MONTAGUTI, Sergio. I costi di gestione della ristorazione ospedaliera derivati dall'economica combinazione di fattori produttivi. **[The costs of hospital catering derived from an economic combination of factors of production.]** *Tecnica e Metodologia Economale*, Firenze, 1980, July/Aug., vol. 19, no. 4, pp. 254-256, 258, 259.

The author compared the costs of meals in three large (800 to 1,200 beds) hospitals in the Emilia Romagna region, for a balanced diet prepared in the traditional manner in the hospital kitchen. The hospital with the lowest costs operated a positive purchasing policy and dealt with a number of suppliers. The others dealt mainly with one supplier for each product or type of product. The author suggests that proper training should be introduced for purchasing officers.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

1720. VINCENT, Virginie. Le traitement du linge à l'hôpital. **[Treatment of hospital linen.]** *Argus des Collectivités*, Paris, 1980, Sept., no. 321, pp. 20-24.

Three possible solutions to the treatment of hospital linen are considered: (i) the hospital can have its own laundry; (ii) it can send its linen to an outside laundry; or (iii) it can use a rental and service system where a company both supplies the linen and launders it. An undeniable advantage of the last method is that no investment in equipment or in linen is required. The hospital's own laundry is only viable if there are more than five tons of dirty linen per day. Inter-hospital laundries are becoming popular, for example six Assistance Publique laundries in Paris deal with 100 tons a day, and the Rouen communal laundry treats the laundry from 25 hospitals in the area. In some hospitals, each department does its own pre-washing and disinfection. For a hospital which is considering installation of a laundry on site the author proposes a formula for calculating the amount of equipment required: number of beds × (volume of linen/week plus staff linen/week) working days/week × loads/day. For a 100-bed hospital with a staff of 40 there might be 960 kg of linen a week, and one large (20 kg load) machine and one small (7 kg) would be sufficient. It is often difficult to choose the best system with which to obtain the best result at least cost.

HOSPITAL LINEN AND TEXTILES

See also Abstract No. 1720

1721. HANCOCK, Edgar. **Minimizing hospital fire hazards with fire-retardant fabrics.** *Fire*, Tunbridge Wells, 1978, May, vol. 70, no. 875, pp. 592-593.

The Property Services Agency (PSA) of the Department of the Environment became intimately involved with fire-retardant textiles some eight years ago when regular demands for such fabrics were being received from the hospital service. The exacting

laundering standards demanded by hospitals, which had to be based on existing techniques, process and plant, soon showed that the brief would most readily be met by chemically treating cellulosic fibres; the majority of the £1½ million of fabrics provided annually are impregnated printed cotton. The cost of achieving the new standards, about 20 per cent extra, is not excessive when related to life and property. Ten fire resistant standards have now been developed by PSA. In addition to drape fabrics previously mentioned, improvement in fire retardance for upholstery and bedding has been obtained by using treated calico for interliners, mod-acrylics, polyamide, wool/viscose, wool/nylon; also, by suitably back-treating knitted and woven cloths.

1722. RIETH, Bernard G. **Center 'fires' flame-retardant fabrics.** *Hospitals*, Chicago, Ill., 1980, Aug. 16, vol. 54, no. 16, pp. 145-146, 148.

The Veterans Administration Hospital, Buffalo, has tested various fabrics purported by the vendors to meet or exceed the VA's requirements for flame-retardant items used in its hospitals. The hospital has found that most flame-retardant fabrics either are flammable or emit deadly toxic fumes when subjected to heat comparable to that produced in a fire. Others melt and produce an added risk of adhering to the skin when subjected to flames. To evaluate the toxicity of flame-retardant fabrics that did appear to have possibilities for use in hospitals, a smoke toxicity test was developed. The result of these tests on various fabrics are presented in a table. As a result of the tests, one fabric is now mandatory in all VA medical facilities. The tests suggest that in evaluating flame-retardant linen, consideration of the following items is vital: flammability, melting, toxicity, washability and cost-effectiveness.

HOSPITAL DOMESTIC MANAGEMENT

DOMESTIC WORK

1723. PHILIPP, Ernst H. Krankenhausreinigung und krankenhausinterne Umwelteinflüsse aud das Keimwachstum. **[Hospital cleaning and the influence of environmental factors in the hospital on the growth of micro-organisms.]** *Krankenhaus-Umschau*, Kulmbach, 1980, July, vol. 49, no. 7, pp. 566-568.

This is a discussion of the problem of infection in the hospital, the growth of micro-organisms in dry and wet media and the use of disinfectants. New inexpensive bactericidal cleaning concentrates and a new floor-sealing medium which is suitable for any hard floor covering are introduced. The latter contains a bactericidal substance which, it is claimed, can kill germs within 50 minutes.

HYGIENE IN THE HOSPITAL

1724. SCHINDEL, Hans-Joachim. Zur Organisation der Krankenhaus-hygiene. **[The organization of hospital hygiene.]** *Krankenhaus-Umschau*, Kulmbach, 1980, July, vol. 49, no. 7, pp. 559-561.

A review of the legal basis for and organization of hospital hygiene in West Germany

is followed by recommendations on the composition of the hospital's hygiene committee. Its members should include the medical director, the chief nursing officer, an administrator, a specialist in infectious diseases, the hygienist, the nurses responsible for hygiene, the technical director and the disinfection officer. The author provides an operational chart which shows what channels of cooperation, authority and advice should exist between the members of the committee itself and between the committee and the university institute of hygiene, the public health authorities and medical research bodies. The duties of the nurses who have special responsibility for hygiene are also described.

1725. STEUER, W. Aufgaben eines Medizinaluntersuchungsamtes im Rahmen der Krankenhaushygiene. **[Tasks of a Medical Survey Testing Bureau within the framework of hospital hygiene.]** *Öffentliche Gesundheitswesen*, Stuttgart, 1980, Sept., vol. 42, no. 9, pp. 618-623.

The duties of the Public Medical Testing Bureaux in West Germany in regard to hospital hygiene are briefly outlined. These include: the preparation of reports on conditions of hygiene in local authority hospitals and on hospital infections; the provision of expert advice when new hospitals or extensions are planned; consultative activity relating to hospital hygiene; bacteriological and hygiene checks in particular areas, e.g. air conditioning installations; biological checks on disinfection and sterilization arrangements in the hospital; checks in laundries and kitchens; and the provision of information for hospital staff by such means as courses and symposia. The relationship between the provincial Medical Testing Bureau and the hospital is illustrated here with a flow chart, and a table and block graph summarize the Stuttgart Bureau's activity in 1978 in regard to bacteriological checks in hospitals.

INFECTION PREVENTION AND CONTROL

See also Abstract No. 1723

1726. REYBROUCK, G. Die Krankenhaushygiene in Belgien: die Hygiene-Kommission und die Ausbildung von Krankenhaushygienikern sowie Hygienefachkräften. **[Hospital infection in Belgium: the hygiene committee and the training of hospital hygienists and of infection control nurses.]** *Hygiene und Medizin*, Mainz, 1980, vol. 5, no. 4, pp. 165-167.

The establishment of a hospital hygiene committee in Belgian hospitals was made compulsory in 1974. Its members must include the medical director, chief administrator, chief nursing officer, pharmacist, microbiologist and three doctors. The introduction of this legislation stimulated general enthusiasm and a spate of courses, symposia and congresses, followed by a period of stagnation. Since 1978, however, courses have been available for doctors who wish to specialize in hospital hygiene and they can obtain a diploma of 'Medical hygienist in public hygiene and hospital hygiene'. The majority of the doctors who take these courses are microbiologists. Courses consisting of 200 hours of theoretical training and 100 hours of practical work have also been established for the infection-control nurse. Belgian hospitals and clinics will require a total of 40 medically qualified hygienists and 130 infection control nurses. The cost of this training

will be 200 million Belgian francs a year but hospital infection costs at least a thousand million francs per annum. A reduction in the increase of infection from the present level of five per cent to four per cent would cover the cost of this training.

1727. WEWALKA, G. Personelle und organisatorische Voraussetzungen für eine moderne Krankenhaushygiene aus österreichischer Sicht. **[Staff and organizational requirements for modern hospital hygiene from the Austrian point of view.]** *Hygiene und Medizin*, Mainz, 1980, vol. 5, no. 4, pp. 161-164.

The author discusses the organizational basis for hygiene control: the hygiene team in each hospital should have a medically qualified leader, generally a microbiologist, and at least one member of the team should devote all his time to the job. Most Austrian hospitals now have a hygiene committee. The main problems at the moment are the avoidance of unnecessary bureaucracy and the establishment of proper training courses for the members of the hygiene team. Short 14-day courses are available but are not really adequate.

1728. NYSTRÖM, B. Die Organisation der Krankenhaus-infektionskontrolle in Schweden. **[Organization of hospital infection control in Sweden.]** *Hygiene und Medizin*, Mainz, 1980, vol. 5, no. 4, pp. 169-171.

Sweden is divided into 24 counties and the county councils are responsible for medical care and welfare. Hospital infection control is therefore organized on a county basis. An infection control team is based in the county hospital but covers the whole county. Every team includes a clinical microbiologist and infection control nurse; their duties are mainly advisory, the medical director of the hospital being responsible for infection control. Each hospital or group of smaller hospitals has a hospital infection committee and, at national level, the National Bacteriological Laboratory will soon have a hospital infection control unit. Industrially sterilized disposable articles for medical use are controlled by law and the Swedish Health and Social Welfare Department's Institute of Planning and Rationalization has produced reports, recommendations and standard specifications for medical equipment. The Department has also issued guidelines on hospital infection control and regulations concerning the control of hepatitis in hospital staff and on the processing of hospital refuse.

1729. NIEHUES, U. Aufgaben und Möglichkeiten der Hygienefachkraft bei der Bekämpfung von Krankenhausinfektionen—ein Erfahrungsbericht. **[Tasks and opportunities of the infection control nurse in the campaign against hospital infections—report on experience.]** *Hygiene und Medizin*, Mainz, 1980, vol. 5, no. 4, pp. 179-181, 184, 188.

The author's work as infection control nurse in Tübingen University Women's Clinic includes surveys of infection, recording and analysis of cases of infection, the provision of advice on hygiene, the preparation of work programmes and in-service training for hospital staff. She describes the commonest sources and types of infection in obstetrics and gynaecology patients. Her work has already borne fruit: the incidence of urinary tract infection fell from 13.3 per cent to 3.3 per cent within three years of her appointment to the post, and that of post-operative wound infection from 10.9 per cent to 0.8 per cent.

1730. Moro, Silvio. L'igiene ospedaliera come materia di insegnamento nella formazione de aggiornamento del personale sanitario ausiliario. **[Hospital hygiene as a topic in the training and re-training of auxiliary health staff.]** *Ospedale*, Torino, 1980, Aug./Sept., vol. 33, no. 8/9, pp. 220-226.

The problems of training auxiliary hospital staff in infection control include: the discipline's lack of prestige as compared with that of surgery, for example, since hygiene only prevents disease and does not cure; structural and environmental inadequacies in the hospital; staff mobility; lack of enthusiasm among doctors and nurses; lack of time; and the absence of infection control nurses. The author gives the following advice on how to teach hygiene: check your basic preparation; know what you are aiming for; make the presentation of your material lively; give practical demonstrations; vary formal lectures with seminars and group discussions; organize visits; use films and slides; leave time for discussion; and, above all, be brief and to the point.

1731. Dietz, Peter, Böhm, Reinhard and Strauch, Dieter. Untershuchungen zur Desinfektion und Sterilisation von Oberflächen mit ultravioletten Strahlen. **[Investigations on disinfection and sterilization of surfaces by ultraviolet radiation.]** *Zentralblatt für Bakteriologie, Mikrobiologie und Hygiene, 1 Abt., Orig. B*, Stuttgart, 1980, July, vol. 171, nos. 2/3, pp. 158-167.

The value of ultraviolet (UV) irradiation for the disinfection or sterilization of surfaces was assessed by measuring its microbicidal action when spores of *B. anthracis* were placed on small (10× 5 mm) plates of wood, pottery and aluminium, and these germ carriers placed in a UV radiation cabinet. A dose of about 2,000,000 μw s/cm^2 killed all the spores on the aluminium and pottery plates in a few cases, but generally more than a hundred times that dose was not sufficient to produce safe sterilization of the plates. The results with the wooden plates were much worse. The use of UV radiation cabinets is therefore not recommended. The detailed results are given in four tables and three graphs, and a photograph of a UV radiation cabinet is included.

HYGIENE IN THE OPERATING THEATRE

1732. Gräf, W. and Kersch, D. Bakteriologische Bewertung chirurgischer Gesichtsmasken. **[Bacteriological evaluation of surgical masks.]** *Zentralblatt für Bakteriologie, Mikrobiologie und Hygiene, 1 Abt., Orig. B*, Stuttgart, 1980, July, vol. 171, nos. 2/3, pp. 142-157.

The authors briefly trace the history of the use of surgical masks since 1898 and describe an experimental study in which the retention efficiency of the materials used in these masks was evaluated on a test assembly, using standardized bacterial aerosols of *Sarcina lutea* and *E. coli*. The materials tested were: white single-layer paper, white two-layer paper, white multi-layer paper, green multi-layer paper incorporating polyester filter pads, card and muslin. The green multi-layer masks incorporating the polyester filter pads were by far the most efficient, their bacterial transmittance being virtually nil even when they had been used for several hours and had become very wet, or when they had been wetted before-hand. The results of the tests are presented in six tables and there is also a diagram and a photograph of the test apparatus.

1733. CAMPBELL, D. and others. **Comparison of personal pollution monitoring techniques for use in the operating room.** *British Journal of Anaesthesia*, Basingstoke, 1980, Sept., vol. 52, no. 9, pp. 885-892.

The aim of operating theatre pollution monitoring is to build up a set of reliable measurements which can be used in recommending maximum permitted concentrations of anaesthetic gases to which staff may be exposed. There is therefore a need to identify a reliable integrated sampling method suitable for use in operating theatres. Three personal pollution monitors (adsorption tubes, diffusion dosimeters and evacuated bottles) were compared with each other and with infra-red spectroscopy in routinely used operating theatres and under controlled laboratory conditions. All the techniques provided time-weighted average measurements of pollutant concentrations. Tubes and dosimeters measure halothane with greater accuracy than that required by the United States National Institute of Occupational Safety and Health regulations, but neither technique can measure inorganic pollutants such as nitrous oxide. The prototype evacuated bottles tested are unsatisfactory at their present stage of development for the measurement of both halothane and nitrous oxide concentrations. At the present time, surveys of operating theatre pollution can best be carried out using adsorption tubes or diffusion dosimeters for personal halothane concentrations and a portable infra-red spectrometer for measurement of background nitrous oxide concentrations.

STERILIZATION

1734. SCOTT, S. B. R. **Developments in the production of sterile goods appropriate technology.** *Hospital Engineering*, London, 1980, Oct., vol. 34, no. 8, pp. 15-18.

Present day production of sterile goods both in the National Health Service and industry results from a steady and logical sequence of change which has evolved during the past 20 years or so. Factors in this development include: improvements in technology; changing needs of clinicians and nurses in the care of patients; and the need for improvement in the microbiological standards of supplies. Five major changes which have occurred are: (i) establishment of central syringe services; (ii) introduction of central sterile supply departments (CSSDs); (iii) development of theatre service centres or theatre sterile supply units (TSSUs); (iv) introduction of standardized packs—sterile for aseptic procedures and clean for clean procedures; and (v) adoption of a new policy by the Department of Health and Social Security in 1972 replacing CSSDs and TSSUs by the hospital sterilizing and disinfecting unit (HSDU). The three main areas of work for the HSDU are: (i) all sterile requirements for the operating department and disinfected items such as anaesthetic accessories; (ii) special procedure packs for use in wards and departments; and (iii) cleaning and decontaminating complex medical equipment. An effective and satisfactory sterile supply service is dependent on: (i) good communication between user and supplier and between the sterile supply manager and the hospital engineering staff; (ii) adequate supervision and control; and (iii) training and education.

AIR HYGIENE

See Abstract No. 1733

SAFETY MEASURES

See also Abstract No. 1708

HAZARDS, GENERALLY

See also Abstract No. 1684

1735. ABRAMSON, Norman S. and others. **Adverse occurrences in intensive care units.** *Journal of the American Medical Association*, Chicago, Ill., 1980, Oct. 3, vol. 244, no. 14, pp. 1582-1584.

In the 16-bed intensive care unit (ICU) at Presbyterian-University Hospital, Pittsburgh, there were 145 reports of adverse occurrences involving 139 patients during the five-year period 1974 to 1978. The reports included 92 cases of human error (63 per cent) and 53 cases of equipment malfunction (37 per cent). Of the 92 reports of human error, 43 involved the misuse of equipment, 13 communication errors and eight documented instances of nurse understaffing with alleged compromise of patient care. A peak occurrence of reported incidents was found between midnight and 0100. Harm occurred more frequently if the patient was unattended (72 per cent) than attended (49 per cent) during the incident. Mortality for patients with an incident report filed during their ICU admission (41 per cent) was higher than for all ICU patients (21 per cent). The importance of a well-structured incident-reporting programme to minimize problems of human error and device malfunction is stressed. The information to be included on the report form is listed.

1736. MORRIS, E. V. and ISAACS, Bernard. **The prevention of falls in a geriatric hospital.** *Age and Ageing*, London, 1980, Aug., vol. 9, no. 3, pp. 181-185.

All falls which occurred in the geriatric department of Burton-on-Trent General Hospital during 1978 were carefully recorded by nursing staff. A total of 236 falls were noted, twice as many in women as in men, and more than half in women aged 75 and over. Four falls resulted in fracture and 55 in soft tissue injury, but in 75 per cent of the falls the patient suffered no injury. Eighty per cent of 325 patients who were discharged, transferred or died during the year had no falls. Falls occurred at all times of day and night, but the risk of falling was highest in the early morning. Most falls occurred in admission wards or rehabilitation wards and very few in long-stay wards. Patients who fell most were those accustomed to being active and independent. Falls in geriatric hospitals are common, but rarely serious and, while a reduction in the fall rate is desirable, it should not be achieved at the cost of reducing patient activity.

ELECTRICAL HAZARDS

1737. POSCH, W. Haftungsfragen im Krankenhaus aus zivilrechtlicher Sicht. **[Questions of responsibility in the hospital from the point of view of civil law.]** *Österreichische Krankenhaus-Zeitung*. Wien, 1980, May, vol. 21, no. 5, pp. 282-288.

Accidents to patients may occur when electromedical equipment is employed in the hospital and one or more persons may be held responsible. The author examines in

turn the responsibility under Austrian law of the hospital, the doctor, the nurse, the safety technician and the manufacturer.

1738. TOMSIC, K. E. Leitfaden: Sicherheit elektromedizinischer Geräte und Anlagen. **[Manual: safety of electro-medical equipment and installations.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1980, June, vol. 21, no. 6, pp. 365-366, 369-370, 373-378, 380-383.

This comprehensive guide considers the dangers of electromedical equipment and the prevention of accidents under the headings: safety regulations, protection, earthing, classification of equipment, what the user should know, the duties of the supplier, the main sources of faults, servicing and testing. Ten photographs and seven figures are included.

ACCIDENTS IN GAS AND DRUG ADMINISTRATION

See Abstract No. 1756

FIRES AND FIRE PREVENTION

See Abstract Nos. 1721, 1722

PLANNING FOR MASS EMERGENCIES

1739. VINSEL, Douglas B. **Hospitals must plan for nuclear accidents.** *Hospitals*, Chicago, Ill., 1980, Aug. 16, vol. 54, no. 16, pp. 113-114, 116, 118, 121.

While most hospitals have developed effective disaster plans, there is a need to extend such plans to cover radiation-exposure victims whether they result from external disasters or internal accidents within the hospital's department of nuclear medicine, radiotherapy or radiology. It is imperative that hospitals develop a plan to ensure the safety of their patients and staff, including the possible complete evacuation of the hospital. The incident at the Three Mile Island nuclear power plant provided the impetus for York (Pa.) Hospital (14 miles from the plant) to re-examine the comprehensiveness of its disaster programme. Although it was not the hospital designated as a treatment facility for the plant, York was alerted to receive radiation victims; later the complete evacuation of the hospital became a distinct possibility. Though neither of these events took place, the steps taken by the hospital to meet them are described. The chief lesson learned was that disaster plans must be brief, general and have a certain degree of flexibility.

RADIATION HAZARDS

1740. Krafttag för bättre strålskydd. **[Measures for improving protection against radiation.]** *KS-Nytt*, Stockholm, 1980, no. 3/4, pp. 3-6.

The Radiology Department of the Karolinska Sjukhus has identified a series of measures by which the number and strength of X-ray exposures are reduced, thereby increasing the safety of patients and improving the working environment of its staff.

First, mechanical reliability was ensured by establishing maintenance contracts with outside firms; the contracts were financed from the sale of old, exposed X-ray film. Operator reliability comes from two sources: the provision for each piece of radiological equipment of its own detailed operating instructions, written in non-technical language, as well as information on how to prepare patients for examination by that particular machine; and training courses in radiation protection given to nurses and technical assistants in radiological departments. In operating theatres monitoring instruments record and check amounts of radiation received by individual patients, and by linking X-ray equipment to amplifiers and TV-screens excellent images are obtained with much smaller X-ray exposures. It is equally important to ensure that doctors, and medical students, are aware of the dangers of radiation as well as the benefits of X-ray diagnoses, and that they take both into account when referring patients for radiological investigation.

THE PATIENT

ADMISSION AND RECEPTION

See also Abstract No. 1707

1741. VISSER, A. Ph. **Effects of an information booklet on well-being of hospital patients.** *Patient Counselling and Health Education*, Princeton, N.J., 1980, vol. 2, no. 2, pp. 51-64.

Following a review of the literature on information booklets, an experiment in two 35-bed surgical wards in a large Dutch regional medical centre is described. The information booklet developed and used on both wards gave information about ward procedures, operative routines, anaesthesia and psychosocial care possibilities. Both before and after introduction of the booklet, data was gathered on the satisfaction, knowledge and emotional state of the patients on the two wards and their perception of the care climate. On one of the wards, staff nurses were trained in counselling skills; measurements were repeated on both wards after this intervention. In a third phase of the study, some of the patients on the experimental ward had a supportive and informative talk with a trained nurse. Although patients appreciated and read the booklet better than a general hospital leaflet, the results showed that the booklet and other supporting measures had no effect on the patients' perception of their well-being. A list of 64 references to the literature is included.

WELFARE OF THE PATIENT

See also Abstract Nos. 1678, 1741, 1772, 1775, 1781, 1799, 1800

1742. FLETCHER, Charles. **Listening and talking to patients.** *British Medical Journal*, London, 1980, Sept. 27, vol. 281, pp. 845-847; Oct. 4, pp. 931-933; Oct. 11, pp. 994-996; Oct. 18, pp. 1056-1058.

The first in this series of papers shows that failures of communication between doctors and patients are common and are clinically important. The other papers discuss:

(i) the skills and strategies needed for the first part of a consultation—the interview—and ways of acquiring them; (ii) how the second part of the consultation, called the exposition, might be improved so that doctors may tell patients more effectively what they want to know and encourage them to follow advice more closely; and (iii) some difficult problems of communication with foreigners, deaf patients, patients with mental handicap, patients who think they are ill, patients who can be cured and patients who are gravely ill.

1743. LAURS, Paul. Ombudslieden en klachtenbehandeling in de psychiatrie. **[Ombudsmen and complaints handling in psychiatric hospitals.]** *Ziekenhuis*, Utrecht, 1980, Sept. 3, vol. 10, no. 17, pp. 490-493.

Though patients have a right to complain, their complaints, trivial or serious, are not satisfactorily dealt with. The cause may be structural. There is no satisfactory legislation on patients' rights. Psychiatric hospitals still have the characteristics of closed, hierarchic communities. One-way authoritarian communication, the solidarity of professional groups, the freeing of the doctor-patient relationship, uncertainty when confronted with a difficult but articulate patient, fear of criticism from the outside world, uncertain success of some forms of treatment, all create a barrier against investigations of complaints. Society too carries a responsibility, as 60 per cent of the nursing staff are young and unqualified, compulsory admissions are not always sufficiently justified and statutory regular controls are not always carried out. An ombudsman has to confront all these factors. The choice must be between an ombudsman who is part of the hospital administration and consequently will not interfere with the medical treatment, or an outside independent ombudsman who does not have to accept medical authority when defending the patient's right to self-decision on his treatment. Plans at present being worked out by organizations including the National Hospital Council should include well defined legislation on patients' rights and independent powers for the ombudsman with a clear definition of his tasks.

1744. JACOBS, D. Het overleg tussen de patiëntenraad en de directie van psychiatrische centra. **[Consultation between the patients' committee and the administration in psychiatric hospitals.]** *Ziekenhuis*, Utrecht, 1980, July 16, vol. 10, no. 13/14, pp. 402-406.

The paper is the second of two articles based on a survey of patients' committees in various hospitals. A balanced relationship should exist between committee and hospital administrations and patients should be able to present their interests without hospital guidance. As these committees have as yet no legal status, their functions in different hospitals varied from an advisory role to independent bodies with certain accepted powers. Some had a detailed working system of meetings and voting, but their importance should lie in their influence on the total hospital administration. Public relations efforts ranged from reports of meetings and interviews with patients to relationships with the press and communication with other regional and national patients' organizations. Discontinuity of membership arising from regular discharge of patients is inclined to impede good functioning and some committees were regularly supported by staff such as psychologists and social workers. The work of patients' committees in administrative matters has some similarities to that of works councils in industry. The question whether patients' committees will grow into legalized effective

patients' representations or wither away under the increasing trend of short time treatments is left open. Their aim should remain to assist in improving quality and quantity of patient care.

1745. COLLEDGE, Julian. **Visiting the mentally handicapped in residential care.** *British Journal of Psychiatry*, Ashford, 1980, Oct., vol. 137, pp. 313-318.

Various characteristics of the hundred youngest residents in a 1,010-bed hospital for the mentally handicapped were investigated in order to find any association between these characteristics and the frequency of visiting by parents. The age range was from five to 22 years. The findings suggest that early attachment of the parents to the resident is of greater importance for visiting than the resident's present skills and behaviour. The most frequently visited subjects were more likely to recognize people, have some speech and have had a normal appearance as a baby. The unvisited subjects were more likely to have been born with an abnormal appearance and into homes with pre-existing social and emotional problems.

1746. SACKETT, J. and FITZGERALD, J. **Music in hospitals.** *Nursing Times*, Basingstoke, 1980, Oct. 16, vol. 76, no. 42, pp. 1845-1848.

It is in the fundamental area of communication that music has so much to offer psychiatric patients, for it is in itself an emotional, non-verbal communication which affects very powerfully the mind and body. Music has much more than entertainment value and has many aspects which make it versatile and flexible. This paper discusses: music as a means of communication and integration; its effect on patients; the role of the music therapist; the occupational therapist and the nurse in the absence of a trained therapist; music appreciation; music discussion; types of patients; and practical problems.

1747. MUCHLINSKI, P. T. **Mental health patients' rights and the European Human Rights Convention.** *Human Rights Review*, London, 1980, vol. 5, no. 2, pp. 90-116.

Despite a move away from confining patients in psychiatric hospitals, and an increased use of community-based care, the number of patients still detained this way is considerable. In the United Kingdom some 25,000 to 30,000 persons a year are compulsorily detained in hospital. Thus issues regarding their rights are of considerable importance. This paper is in three parts: (i) an analysis of the current case law under the European Convention on Human Rights; (ii) an examination of its effects on United Kingdom practice to the extent that it is being questioned before the European Commission on Human Rights in a series of applications from patients in Broadmoor Hospital relating to conditions of detention, compulsory detention of mentally abnormal offenders and review by mental health review tribunals (MHRT) and habeas corpus proceedings; and (iii) proposals for reform. The main thrust of government proposals is to make the existing powers of review more readily available to the offender patient. Two additional approaches to reform present themselves: (i) extension to restricted patients of the powers of the MHRT to hold a full hearing and making its findings binding on the Secretary of State; and (ii) clarification of the extent to which habeas corpus proceedings could admit a review of the substantive reasons for the Secretary of State's decision.

VOLUNTARY SERVICE, VOLUNTARY WORKERS

1748. **Trustee development program: the hospital auxiliary.** *Trustee*, Chicago, Ill., 1980, July, vol. 33, no. 7, pp. 9-10, 12, 14-16.

The role of the auxiliary in providing volunteer services in health care institutions is outlined by a unit of the United States hospital trustee development programme. An auxiliary is an independent organization of members of the community but is responsible to the hospital administration for the exercise of its rights. Members of an auxiliary may or may not be in-service volunteers. The auxiliary president is chiefly responsible for liaison with the administration and procedures for communication should be clearly defined. The activities most frequently carried out by the auxiliary include: (i) providing a link between the hospital and the community; (ii) raising funds for the hospital; and (iii) helping to improve delivery of the health care system. The hospital may formally recognize the auxiliary by: (i) adopting a provision in the hospital bye-laws to set up an auxiliary; or (ii) recognizing the auxiliary as a separate legal corporation affiliated to the hospital. In addition, the governing body should: (i) approve the auxiliary's bye-laws; (ii) approve the investment of fund raising monies; (iii) ensure proper audit of the auxiliary's financial statements; (iv) involve the auxiliary in the hospital's long term plans; and (v) consider suitable auxiliary members for appointments on board committees.

HOSPITAL SOCIAL WORK

See also Abstract Nos. 1774, 1783, 1791

1749. REHR, Helen, editor. **Professional accountability for social work practice: a search for concepts and guidelines.** New York, Prodist, 1979. xiii, 210pp. ISBN 0 88202 127 3

This book is based on the authors' experience of introducing a programme of professional accountability at the Department of Social Work Services, Mount Sinai Hospital, New York. Subjects discussed are: the implications for hospital social work of the importance now attached to professional responsibilities; accountability for quality of care and efficiency in delivery of services; the place of social work in utilization review, with particular attention to discharge planning and effective bed utilization; statistical maintenance, quantitative assurance and analysis and the structural needs to secure these, with a description of the social work services data system at Mount Sinai; the recording of social work information on the patient's medical chart; the development of a peer review system, where the professional advantages must be set against the high cost of the system initiated at Mount Sinai; methods for audit of social work intervention in a health care setting; the relationships between continuing education, peer review and the concept of the self-directed worker; preparation for professional accountability as part of social work education; the reactions of social work service staff to the introduction of the professional accountability programme at Mount Sinai; a review of the Mount Sinai project and a consideration of the future pattern of social work in health care.

TRANSPORT OF PATIENTS

See Abstract No. 1786

HOSPITAL CARE

See also Abstract Nos. 1776, 1779, 1788, 1803, 1804

1750. MARKUS, Andrew. **Medical audit: what can we learn from the American experience?** *Update*, London, 1980, Nov. 1, vol. 21, no. 9, pp. 1066-1067, 1071-1072.

Medical audit, or planned examination of medical care, has become a much-discussed subject in the United Kingdom, but has been established in the United States for a long time. This paper discusses United States experience and its relevance for the United Kingdom. It covers: the present situation; rigid criteria; non-compliance; re-audit; the value of audit; justifiable scepticism; and restriction of clinical freedom. Whilst the provision of data from structure audit helps in making decisions regarding the planning of health care, the place of process audit seems to lie clearly in the field of continuing medical education, the success of which can be assessed by outcome audit. In the United Kingdom the best way of using this technique could be through the use of small-group audit meetings. Medical audit has the potential for: (i) setting professional standards; (ii) assessing clinical performance; and (iii) modifying clinical behaviour.

TERMINAL CARE

1751. POSS, Sylvia. **How the terminal patient accepts dying.** *Patient Counselling and Health Education*, Princeton, N.J., 1980, vol. 2, no. 2, pp. 72-77.

This paper identifies and discusses six parallel but related problem-solving tasks on which the dying must work in order to master the terminal crisis: (i) becoming aware of impending death; (ii) balancing hope and fear; (iii) making an active decision to reverse survival processes; (iv) relinquishing responsibility and independence; (v) separating oneself from former experience; and (vi) spiritual preparation. While engaged in these tasks the patient experiences many emotions. Once an individual has accepted death, feelings of preparedness, peace and achievement accompany the fulfilment of the problem-solving tasks, and the crisis is over. The patient is then ready to die with dignity.

1752. MCGRORY, Arlene. **A well model approach to care of the dying client.** New York, London, McGraw-Hill, 1978. xi, 180pp. bibliogs. ISBN 0 07 045094 3 £5.20

After putting forward reasons for analysing feelings about death and considering the obstacles to choice of treatment for dying patients, the author outlines a 'well model' approach to nursing. The concepts important for this model are health, wellness, adaptation, stress, equilibrium, margin of equilibrium safety, sickness and maladaptation. The application of the model to the nursing process and care of the

dying patient is described; crisis, grief, body image and pain are identified as important concepts in dying. Care of the acutely ill and care of the chronically ill dying patient are given separate consideration, and curriculum guidelines for nurse education are presented. Discussion questions and bibliographies appear at the end of each chapter.

1753. FEIGENBERG, Loma. **Terminal care: friendship contracts with dying cancer patients.** New York, Brunner/Mazel, 1980. xxii, 282pp. bibliog. ISBN 0 87630 224 X £13.25

After outlining his own views on death and dying, the author describes his 'friendship contract' approach to the care of dying cancer patients; this involves establishing close personal contact, to the exclusion of contact by the physician with the patient's relatives and the regular nursing staff. Important features of the relationship are: (i) there is intensified personal contact and growing mutual confidence; (ii) open communication is encouraged, but on the basis of strict confidentiality; (iii) the relationship is a new one, and akin to friendship; and (iv) the physician, who does not come into contact with the patient's relatives, can help with problems and emotions which the patient may not wish to share with his relatives. Five case histories are given. A survey of the literature on death and dying is included as an appendix.

1754. TWYCROSS, Robert Geoffrey and VENTAFRIDDA, Vittorio, editors. **The continuing care of terminal cancer patients: proceedings of an International Seminar on Continuing Care of Terminal Cancer Patients, Milan, 19-20 October 1979.** Oxford, Pergamon, 1980. xix, 280pp. bibliogs. ISBN 0 08 024943 4 £20.00

This seminar was concerned with the role and responsibility of the physician in the care of patients dying from cancer. The papers are divided into six sections: (i) moral and legal aspects of terminal care; (ii) communication between physician and patient and emotional aspects of terminal illness; (iii) pain relief; (iv) the control of other symptoms, physical therapy and rehabilitation; (v) nutrition; and (vi) management and organization of terminal cancer care. Most of the papers include references to the literature.

DISCHARGE OF PATIENTS

See Abstract No. 1705

HOME CARE, AFTER-CARE

See also Abstract Nos. 1805, 1806

1755. CURRIE, C. T. and others. **A scheme of augmented home care for acutely and sub-acutely ill elderly patients: report on pilot study.** *Age and Ageing*, London, 1980, Aug., vol. 9, no. 3, pp. 173-180.

A pilot study for a scheme of augmented home care for a selected group of elderly patients with acute illness was carried out by the Geriatric Unit at the City Hospital, Edinburgh. General practitioner care was supplemented by the services of a geriatrician and home help and district nursing services were involved when required. Functional

recovery was assessed using an index of activities of daily living based on the patient's functional ability prior to illness. Of the 37 patients treated at home, six required admission to hospital and three died. The remainder made a satisfactory functional recovery, three to a level greater than previously and 10 to a slightly lower level. Preliminary evidence suggests that, in a group of elderly patients with similar illnesses, recovery of function is more rapid at home than in hospital. The home care scheme was acceptable to patients and helpers alike and further controlled studies should be carried out into this type of care.

SPECIAL DEPARTMENTS

ANAESTHESIA

See also Abstract No. 1733

1756. UZEL, Pierre. Les incidents d'anesthésie. **[Accidents in anaesthesia.]** *Techniques Hospitalières*, Paris, 1980, Aug./Sept., vol. 35, no. 419/420, pp. 37-38.

Accidents in anaesthesia are discussed from the point of view of the legal liability of the anaesthetist and the hospital. Such accidents include lesions of the mouth and teeth, complications of intravenous injections, paralysis due to the patient's being immobilized for too long on the table, cardiac arrest, burns, dermatitis, tracheal stenosis and explosions. The anaesthetist is obliged to monitor the patient until the latter wakes up, and the hospital is responsible if he has been absent from his post when an accident occurs. Additional problems arise when private practice surgery is done in public hospitals. In general, the full-time private sector surgeon must be insured against all risks, but in awarding damages the court may want to know whether the organization of the hospital department was adequate to cope with an unforeseeable anaesthetic mishap.

PHARMACY

See also Abstract No. 1784

1757. SCHMIEDING, Janet L. and SITA, Michael J. **Key inventory to formulary to cut drug costs.** *Hospitals*, Chicago, Ill., 1980, Sept. 1, vol. 54, no. 17, pp. 78-81.

Lutheran Medical Center, St Louis, used to carry an excessive drug inventory for a 420-bed hospital. In 1978 it was decided to make a two-pronged attack on the situation: (i) development of a generic formulary and elimination of duplicated brand names to reduce the inventory; and (ii) implementation of modern business practices in purchasing and inventory to keep future purchases under control. The compilation of the formulary is described. The principles governing it were: (i) the formulary is an alphabetical listing of drugs by generic nomenclature; (ii) a pharmacological-therapeutical listing of drugs is given; (iii) there is a need for a mechanism for routine review of present and new drugs by the pharmacy and therapeutics committee; and (iv) only the drugs listed in the formulary should be stocked by the

pharmacy. While the formulary was being compiled, changes were made in the store room to match the generic system. After 18 months of experience, the results were impressive; the inventory and the expenditure on drugs were reduced.

1758. HIBBERD, Patricia L. and MEADOWS, A. J. **Use of drug information sources by hospital doctors.** *Journal of Information Science*, Amsterdam, 1980, Oct., vol. 2, no. 3/4, pp. 169-172.

In a survey to find out how hospital doctors learn about new drugs and check on basic prescribing details, questionnaires were sent to 300 doctors in five hospitals in the Leicester area, whilst 46 doctors randomly selected from the same hospitals were approached for parallel interviews. The response rate for both questionnaires and interviews was about 50 per cent. It was found that 85 per cent of the respondents used the commercially produced *Monthly Index of Medical Specialities* (*MIMS*) to learn about the existence of a new drug, but the majority turned to sources of information produced by the medical profession to learn about the efficacy of a new drug. *MIMS* was considered an important source for checking on most basic prescribing details, but was closely rivalled by the *British National Formulary*. Although there are numerous drug information sources in existence, it appears that no available source meets all the needs of the prescribing doctor. It is suggested that this unsatisfactory situation might be overcome by: (i) producing a revised type of drug reference manual; and (ii) providing a comprehensive drug information service run by clinical pharmacologists and drug information pharmacists with co-operation from the pharmaceutical industry, to back up this manual.

1759. PAINEAU, Jean. Les stupéfiants a l'hôpital. **[Narcotics in hospital.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1980, Aug./Sept., no. 198, pp. 645-649.

French law requires that certain procedures be carried out in regard to the holding of stocks of narcotics in hospital pharmacies, ward cabinets and emergency cabinets. Narcotics may only be administered to the patient if a prescription is made out with his name on it, the dosage and the date. The pharmacist may only give narcotics to a person who is authorized to prescribe them, or to the ward sister. The stock of narcotics in the emergency cabinet must be determined annually after consultation between the pharmacist and the head of the department concerned, and the pharmacist must check the contents of the cabinet monthly in the presence of the hospital administrator. The author suggests various means by which thefts of narcotics may be reduced or prevented. When a theft does occur, a list of the staff present at the time must be prepared immediately and the Ministry of Health, the police, and the regional Inspectorate of Pharmacy informed. French laws on the subject of narcotics have been amended from time to time in the light of advances in knowledge, and work has begun on adjusting this legislation to EEC directives.

1760. CARLIER, A. Modalités et motivations de la dispensation individuelle des médicaments. **[Methods and motivations for individual dispensing of drugs.]** *Gestions Hospitalières*, Mantes-la-Jolie, 1980, Aug./Sept., no. 198, pp. 635-643.

The percentage of errors arising in conventional drug distribution systems in hospital is never less than 15 per cent, and nearly always between 20 and 30 per cent. Concern about this has led to the introduction of the unit dose system, which the

author describes, in the USA and elsewhere. The author analyses current methods of drug distribution in France and shows how the introduction of the unit dose system would benefit doctors, nurses, pharmacists and administrators alike. He discusses at some length the factors which may make the unit dose system acceptable to these groups.

1761. MAXWELL, J. **Assessment of workload in hospital quality control laboratories.** *Journal of Clinical and Hospital Pharmacy*, Oxford, 1980, Sept., vol. 5, no. 3, pp. 251-258.

The Trent Regional Health Authority has seven pharmacy areas, each with area quality control facilities. One area has two quality control laboratories and the remainder have one each. Basic equipment is common to all the laboratories. Regional specifications and worksheets for finished products and raw materials have been developed so that each laboratory tests to the same specification. A system for assessing the work load of the staff working in the quality control laboratories has been developed over a three-year period. Each laboratory completes a monthly summary of the work done from data available in the laboratory log book. Cumulative totals are kept and at the end of each year an annual report is published. Since the amount of each particular type of work varied between laboratories, it was necessary to reduce the varying activities to a common factor. This common factor was the time involvement in each activity. To save staff time, all tests are converted to time using four approximations. Data are presented which indicate that the system has achieved its objectives. The implications for improved use of expensive manpower are outlined.

LABORATORIES

1762. LEITGEB, H. Laborautomation im Rahmen des KIS-Salzburg. **[Laboratory automation within the framework of the Provincial Hospital in Salzburg.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1980, June, vol. 21, no. 6, pp. 338-340, 342.

The author briefly outlines the purposes for which computers are used in the Provincial Hospital in Salzburg. These include: patient records, patients' invoices, accounts, stores, menu choice, inventories, staff information system, laboratory investigations, in nuclear medicine and in the radiotherapy unit. He describes the organization of laboratory routines. The hardware in the laboratories comprises one IBM 5/7 computer with a reader, two console printers, one rapid printer, three matrix printers and three video terminals. The administrative work of the laboratory staff has been substantially reduced by the use of computers, and a staff of three doctors, two chemists, 15 technicians, two laboratory assistants and three secretaries can deal with 950,000 analyses for 37,000 in-patients and 9,000 out-patients a year in this 1,600 bed hospital.

1763. ACKERMAN, V. P. and others. **Reporting practices of microbiology laboratories.** *Journal of Clinical Pathology*, London, 1980, Sept., vol. 33, no. 9, pp. 830-835.

A set of laboratory records on investigations of typical specimens were circulated

to Australian hospital microbiologists. They were asked to draft reports on the data provided as if the investigations had been carried out in their own laboratories. Many laboratories reported the results of their findings without any explanations and more variations were found in the interpretation of results than is desirable. Some microbiologists gave judgments which cannot be made from laboratory data alone and several made unnecessary requests for the test to be repeated. The survey revealed the following factors which led to unsatisfactory results: (i) inflexible views on what is pathogenic; (ii) the use of vague reporting conventions; (iii) concealment of culture results; and (iv) failure to indicate the possibility or otherwise of a definite conclusion.

BLOOD TRANSFUSION DEPARTMENT

1764. STAALLEKKER, L. A., STAMMEIJER, R. N. and WIT, C. Dudok de. **A Dutch blood bank and its donors.** *Transfusion*, Hagerstown, Md., 1980, Jan./Feb., vol. 20, no. 1, pp. 66-70.

The number of blood donors in the Netherlands is not keeping pace with the increasing need for blood. To study the factors which motivate people to donate blood, a questionnaire was sent to a group of prospective donors, current donors and ex-donors. The most usual incentive to become a donor was a direct approach by another donor. Serving a good cause was central to the donors' motives, but receiving a regular medical check-up also played a significant part. About half the donors considered the check-up was too superficial and a much smaller number complained of the distance travelled to the collection point and the time spent there. The most common reason for stopping donation was poor health, but a few complained of practical inconveniences caused by how the service was run. The Dutch system, whereby no financial remuneration is offered for donation of blood, seems to be satisfactory. However, the survey justifies further research on the connection between donor motives and the way in which the blood bank is run.

1765. EGGERT, A. A., TRAVER, M. I. and BLANKENHEIM, T. J. **A computer-based record system for a hospital transfusion service.** *Transfusion*, Hagerstown, Md., 1980, Jan./Feb., vol. 20, no. 1, pp. 55-65.

In July 1977 an on-line computer system for recording blood transfusion service activities was added to a general clinical laboratory system for the University Hospitals at Madison, Wisconsin. The system provides: (i) an easily readable, complete daily record of units of blood cross-matched and units transfused for each patient, sorted by name; (ii) a record of the final disposition of each unit of blood or blood component; (iii) automatic drawing up of patients' bills; and (iv) a record of the laboratory's work load. Data given to the computer are stored in files and two out of four files contain data generated by blood bank activities. The file contents and the operation of the following computer programs are described: (i) blood inventory program; (ii) patient blood type program; (iii) cross-match and issue program; (iv) return blood program; and (v) the patient blood report. The system has reduced manual clerical operations from 12 to 14 hours per day to eight or less. Acceptance of the system by medical technologists has been excellent and several additional programs are planned.

1766. CLARKE, John R. and others. **Optimal blood ordering for emergency department patients.** *Annals of Emergency Medicine*, Lansing, Mich., 1980, Jan., vol. 9, no. 1, pp. 2-6.

Criteria for the appropriate use of banked blood are necessary to minimize waste of this critical resource. A lack of documented criteria for determining which emergency patients should have blood crossmatched for possible transfusion led the authors to review the records of all patients for whom blood was crossmatched in the emergency unit of the Hospital of the Medical College of Pennsylvania in 1977. A total of 1,230 units of blood were crossmatched for 378 patients. Within the guidelines of the investigation, 703 units were crossmatched for 273 patients (72 per cent) who did not receive transfusions and 537 units for 105 patients (28 per cent) who received transfusions; of the latter 331 units were transfused. Of 12 variables examined, those showing a positive relationship to transfusion were consolidated into four criteria: (i) shock; (ii) haematocrit less than 30 per cent; (iii) observed blood loss of at least 500 ml or grossly visible gastrointestinal bleeding; and (iv) emergency surgery with anticipated blood loss. Application of these criteria identified 55 per cent of patients who did not receive transfusions and 41 per cent of units unnecessarily crossmatched, while failing to identify only three patients receiving single-unit transfusions. Use of the criteria would have reduced the crossmatch/transfusion ratio from 3.7:1 to 2.6:1.

DIAGNOSTIC X-RAY DEPARTMENT

See also Abstract No. 1673

1767. GÉZA, Adam, GYÖRGY, Csákány and GÉZA, Mányi. A röntgendiagnosztikai osztályok funkciója, szervezete és épületszükséglete. **[Functions, organization and building requirements of the diagnostic X-ray departments.]** *Egészségügyi Gazdasági Szemle*, Budapest, 1980, June, vol. 18, no. 2, pp. 168-185.

The importance of international co-operation in the field of radiology as well as patient care is emphasized. Information is given about Hungarian equipment standards, room requirements and the siting of radiology units—whether at polyclinics, hospitals or regional centres. The prospective number of radiologists and X-ray assistants is discussed together with operational principles and storage systems. Five plans are included.

1768. SWINBURNE, Kenneth. **Medical education and the X-ray department.** *Journal of the Royal College of Physicians of London*, London, 1980, Oct., vol. 14, no. 4, pp. 245-246.

Failure to teach anatomy in pre-clinical medical courses has led to widespread ignorance on the part of young graduates in the X-ray department. The author considers that experienced radiologists represent an untapped source of teachers in this field. In addition, the current trend is to undertake numerous diagnostic investigations, some of which may be irrelevant to the patient's problem. This leads to doubt and confusion, further investigations and prolonged attendance at out-patient clinics. The routine diagnostic 'work-up' has no logical place in clinical practice and its use should be excluded from medical teaching. A system which: (i) selects tests which are

appropriate to the problem; (ii) eliminates wasteful investigations; and (iii) reduces discomfort and possible danger to the patient, should be introduced into both medical education and clinical practice.

1769. SUTHERLAND, G. R. and SHIMMINS, J. **NMCC Radiology Subcommittee report—the application of an administrative computer to departments of diagnostic radiology.** *Health Bulletin*, Edinburgh, 1980, Sept., vol. 38, no. 5, pp. 203-207.

A critical approach to the application of a computer to the administrative problems of a radiology department is essential. The principal objective is to improve the quality of department performance whilst, at best, reducing or at least holding clerical staff costs in the face of an increasing work load. In order to obtain these benefits the system must be carefully planned with particular emphasis on the practical work of functions included in the system. The principal areas of application, already established and shown to be effective and useful in the Glasgow area, are: patient documentation; report preparation and distribution; film delivery lists; register of patient attendances; department statistics and performance data; disease indexing; interesting examination teaching file; patient index; evaluation of work in progress; film envelope trace file; booked examination list; and on-line X-ray report file. Guidance is given on the design and cost of practical systems, with illustrative examples.

1770. PREES, Mike. **Speeding up the system.** *Health and Social Service Journal*, Basingstoke, 1980, Sept. 19, vol. 90, no. 4711, pp. 1235-1237.

A computer-based radiology system has been developed at the Norfolk and Norwich Hospital, partly because of the hospital's somewhat unique arrangement of X-ray facilities—three distinct departments covering in-patients, out-patients and accident and emergency functions and two in smaller hospitals. The system is designed as four main sub-systems, each with its supporting file maintenance facilities, and each playing its part in the achievement of the common goals of better control of film locations, commonality and efficiency of reception procedures in all departments, ease of reporting and better appointment scheduling. The system is based on a Ventek 5500 central processor, using Datashare timesharing software, with a disk drive unit for backup storage. A Centronix 330 cps printer carries the main printing burden. Normal access is via eight Datapoint 3600 visual display units and keyboards; small slave printers are attached to some of these. The use of the system is described in some detail.

PHOTOGRAPHY DEPARTMENT

1771. CORDELL, William, ZOLLMAN, Wallace and KARLSON, Henry. **A photographic system for the emergency department.** *Annals of Emergency Medicine*, Lansing, Mich., 1980, April, vol. 9, no. 4, pp. 210-214.

Photography is a rapid, relatively simple, and inexpensive means of documenting patient care and enhancing medical education. Because of its use in medical records, photography affords the physician added defence against claims of medical malpractice. This paper describes a basic photographic system for an emergency department, including suitable cameras and other equipment. It also offers advice on camera

operation, filing procedures and picture composition, and discusses the medicolegal implications of medical photography. Recommendations on the purchase of essential equipment are made.

OCCUPATIONAL THERAPY DEPARTMENT

1772. FURNHAM, Adrian, KING, Joan and PENDLETON, David. **Establishing rapport: interactional skills and occupational therapy.** *British Journal of Occupational Therapy*, London, 1980, Oct., vol. 43, no. 10, pp. 322-325.

A social skills training course was introduced at Dorset House School of Occupational Therapy, Oxford, in 1978. The course has been run a number of times for groups of 15 to 20 students at second and third levels of training. The course comprises five separate sessions, each of two to three hours' duration, following the introduction which is concerned with establishing the content as well as the appropriate roles and responsibilities of the participants. Each student is given a 10-page booklet which contains all the relevant course material. The five sessions are on: (i) non-verbal communication; (ii) verbal communication and behavioural description; (iii) identifying and coping with emotions; (iv) role play—colleagues; and (v) role play—patients.

DEPARTMENTS FOR SPECIAL THERAPY

See also Abstract No. 1807

1773. BOLTON, John. **Special environments for health care.** *Health and Social Service Journal*, Basingstoke, 1980, Sept. 12, vol. 90, no. 4709; centre eight pages, pp. M2-M8.

This paper attempts to provide a conspectus of past and present practice and a forward look in the matter of special environments for health care. It is a philosophical and technical review rather than a detailed technical analysis of the subject. The review covers: operating departments; nursing and containment of contagious diseases; sterile environments for susceptible patients; pathology laboratories; post mortem rooms; and manufacturing pharmacies. Whatever decision is taken about the degree of protection to be provided by way of special environments, it is suggested that this review and recent experience in the United Kingdom demonstrates one moral —the need for a clear and agreed working procedure. With such an agreement, engineering responsibilities for equipment can be assessed and checked as can the various other professional responsibilities. In the United Kingdom, it is hoped that codification of the risks and situations (as far as possible) will ensure proper matching of the environments and facilities to the risks involved.

1774. ADDISON, Carole. **Tolerating stress in social work practice: the example of a burns unit.** *British Journal of Social Work*, London, 1980, vol. 10, no. 3, pp. 341-356.

The social worker in a burns unit will be exposed to extreme stress, arising both from the nature of the caseload and the nature of the setting. Because burns patients are often very young, socially deprived or the victims of accidents or violence, the

social worker needs a wide range of skills. Despite recent advances in treatment, severely burned patients remain ill for a long period and their reactions may include acute grief, anger and withdrawn behaviour. The burns unit social worker is faced with the usual problem of finding her role in the multi-disciplinary team and when she has commitments in other parts of the hospital this may be even more difficult. In addition, the level of stress in the unit is likely to have a profound effect on her life and personal adjustment. However, staff and patients generally pass through stages of adjustment in which group support gives hope to the struggle for recovery. If the social worker can join in this process she may be able to offer help to patients without being overwhelmed. Stress can be contained if informed personal support is available, but in such a highly specialized unit this is not always the case.

INTENSIVE CARE UNITS

See also Abstract Nos. 1701, 1735, 1786

1775. BERNHARD, P. and STUDT, H. H. Psychosomatische Aspekte in der Intensivmedizin. **[Psychosomatic aspects in intensive care.]** *Krankenhausarzt*, Karlsruhe, 1980, Sept., vol. 53, no. 9, pp. 701-705.

A series of 40 patients in an intensive care (IC) unit was questioned about the psychological aspects of their illness in an effort to discover whether they all experienced the same stresses and withstood anxiety in the same way. They were divided into four groups of ten: ten with myocardial infarct, ten on intubation and suffering to some extent from amnesia, ten who had been transferred to IC from another ward and a final miscellaneous group of ten patients who were unconscious. Almost all the patients were frightened of dying when admitted to IC but soon felt confident and secure; by the third day in IC they felt that they were being well taken care of. Those who appeared to suffer the most psychologically were the intubated patients and those who had been transferred from another unit; their anxiety tended to increase with length of stay. Continuous contact with close relatives was found to be of the greatest importance in maintaining the patient's mental equilibrium. On the basis of their findings the authors make recommendations on the subject of visiting, on the need for contact and non-verbal communication which is experienced by the intubated patients and on the use of psychotherapy in a few cases. They suggest that some of the patients transferred from other wards improve psychologically when they return there or when they receive a visit from the doctor treating them there.

SPECIALIZED HOSPITALS AND UNITS

OUT-PATIENT

1776. DOVE, Henry G. and SCHNEIDER, Karen C. **The application of prognostic criteria in out-patient quality assessment: control of hypertension.** *Journal of Medical Systems*, New York, 1980, vol. 4, no. 1, pp. 45-58.

In order to evaluate the quality of medical care, it is usual to examine what ultimately happened to a sample of patients (outcomes) or to review the medical interventions

or processes of patient management. So most medical audits use either outcome criteria or process criteria. The purpose of the project reported in this paper was to test the feasibility of a new method for the assessment of the quality of out-patient care in Veterans Administration hospitals in which both process and outcome were examined. The technique involved three steps: (i) collecting data on a short-term outcome for a clinical problem; (ii) creating prognostic classification criteria; and (iii) using the results of steps (i) and (ii) to analyse, adopt and use process criteria for audits. The innovative feature of the method was the use of prognostic classification criteria. These are a set of patient attributes or characteristics (baseline characteristics) that subdivide patients into distinct groups or strata. The method was tested using the blood pressure control of 352 hypertensive patients. Use of the prognostic classification criteria led to two significant findings, which would have been obscured without stratifying the patients.

1777. FRIEDMANN, Claude T. H. and others. **A combined crisis-out-patient clinic: a better system for delivery of psychiatric care?** *Hospital and Community Psychiatry*, Washington, D.C., 1980, Aug., vol. 31, no. 8, pp. 555-557.

In January 1977 the psychiatric crisis clinic and the out-patient clinic at Harbor General Hospital, Torrance, California, were merged. A number of administrative changes have been made to speed up the assessment of new patients. Patients are seen within three days of asking for an appointment and 12 new patients are seen every two hours. The new clinic has simplified the patient flow between crisis and longer term treatment. A greater number of patients receive the same number of units of service and staff time has been saved. The combined clinic has improved staff morale by allowing them to provide a range of services for a variety of patients. The concept of combining crisis and longer term care within one out-patient clinic seems to be a promising method of handling the increasing diversity of psychiatric out-patient needs.

CASUALTY AND ACCIDENT

See also Abstract Nos. 1674, 1676, 1677, 1686, 1766, 1771, 1777, 1808, 1809

1778. BURNS, Steve and WIEGENSTEIN, John G. **Patients, charts, and orders: keeping track.** *Annals of Emergency Medicine*, Lansing, Mich., 1980, Feb., vol. 9, no. 2, pp. 92-95.

A simple, inexpensive system for keeping track of charts, orders and patients in a busy emergency department has been developed at Ingham Medical Center, Lansing, Mich. All orders, except the most urgent, are communicated in writing. A secretary relieves the nurses of secretarial duties, and functions as co-ordinator of laboratory work and communications. A traffic board, using magnetic markers, provides instant visual presentation of the state of the department. Swift movement of patients from room to room can occur without losing track of the patient or his chart. A system of six discrete chart stations is used, each denoting a separate task to be done. The chart moves in an orderly manner through the stations, giving the staff 'at a glance' information about what must be done and how well the department is processing patients. A scribe option is used to increase the throughput of patients when the department is

very busy. This allows the physician to go directly from patient to patient in the most expeditious manner. The scribe is a nurse who, when called upon, leaves his usual duties to accompany the physician and take down his orders.

1779. OGNIBENE, Margaret, MCNITT, Helaine and WOLCOTT, Barry W. **The time relationship of performance and audit feedback on conformance with emergency department process criteria.** *Annals of Emergency Medicine*, Lansing, Mich., 1980, March, vol. 9, no. 3, pp. 123-125.

Adherence to physician-developed process criteria is critical to the medical and legal acceptance of algorithm-directed non-physician care of acute non-life-threatening illnesses seen in the emergency department. It is generally assumed that adherence to prescribed medical process criteria results in acceptable patient outcomes. At the Brooke Army Medical Center, Fort Sam Houston, Texas, an evaluation was made of changes in compliance with varying time delays in audit feedback and varying degrees of supervision. This indicated that, under ideal circumstances of daily audit and supervisory feedback, a conformance rate of 80 per cent was achieved. This was a 100 per cent improvement over a group in which neither element was operative.

DAY HOSPITALS

See also Abstract Nos. 1785, 1789, 1790

1780. LODGE, Brian. **Day hospitals for dementia.** *Practitioner*, London, 1980, Oct., vol. 224, no. 1348, pp. 1077-1079, 1081-1082.

The day hospital for the elderly patient with organic mental disorder deals predominantly with those suffering from dementia. This paper discusses: the role of the day hospital; indications for day hospital care (assessment, therapy or supervision, social relief); buildings; staff; transport; hours of attendance; therapy; functional model of dementia; areas of therapy; continuity with community care; and mental aids to daily living.

CHILDREN

See also Abstract Nos. 1665, 1745

1781. CARPENTER, Sallie. **Observations of mothers living in on a paediatric unit.** *Journal of Maternal and Child Health*, London, 1980, Oct., vol. 5, no. 10, pp. 368, 370, 372-373.

The author examined the attitudes of resident mothers on the two paediatric wards at Stoke Mandeville Hospital over a two month period in 1979. Of 266 children admitted, 88 had their mothers resident with them. Fifty of the mothers were interviewed and said they were impressed with the friendly atmosphere of the ward and appreciated being able to stay with their children. Their main problems were boredom, depression and lack of food and sleep. Most mothers felt communication with the doctors was good, but 12 complained they were not given enough information. Mothers tended to be upset if the stay was longer than expected and worried about

the results of additional tests. All except four said they would come with the child again and none anticipated any problems on returning home. Suggested improvements on the unit were: (i) television in every cubicle; (ii) better telephone facilities; (iii) a larger day room and more sleeping facilities for mothers; and (iv) cheaper and more convenient eating arrangements.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 1707, 1736, 1755, 1780

1782. DODD, Kathryn, CLARKE, Michael and PALMER, R. L. **Misplacement of the elderly in hospitals and residential homes: a survey and follow-up.** *Health Trends*, London, 1980, Aug., vol. 12, no. 3, pp. 74-76.

A one-day census of the elderly in institutional care in Leicestershire was held in December 1976; as part of the census questionnaire, staff were asked whether or not they thought each patient in their care was in the appropriate type of institution. This paper describes the findings concerning misplacement and reports on a six-month follow-up survey of the group. Of the 4,514 people over the age of 65 who were enumerated in the census, 434 (10 per cent) were considered misplaced by the staff; six per cent in non-National Health Service establishments were so described compared with 15 per cent in hospitals. An analysis by medical reviewers of the 360 people who had been resident for more than 28 days is presented. The largest proportion of misplaced residents required a place in a residential home, with half of those in hospital beds considered eligible. The follow-up studies revealed that 49 per cent of those regarded as misplaced remained where they had been originally; 35 per cent had been transferred and 16 per cent had died. The implications of these findings are discussed.

1783. YOUNG, Stephen. **Group work in a geriatric setting.** *Social Work Service*, London, 1980, Sept., no. 24, pp. 7-9.

Early in 1976 a pilot group work venture was started in a 75-bed geriatric hospital. Following discussions with medical, nursing and administrative staff and a short report to them on the scheme's aims and objectives, 10 patients were chosen by the nursing officer and the social worker. The pilot scheme ran for 10 weekly sessions. At the end of each session, a short report containing the following information was compiled and given to the nursing officer: list of group members; discussion topics; individual performances; and summary of the group dynamics. During the pilot study the discussion topics fell into three main categories: topics of general interest; news items; and patients' own subjects. At the end of the pilot study, all the patients involved said that they had enjoyed the opportunity of meeting together and exchanging ideas and experiences. The nursing staff reported that the patients were more communicative and positive in their attitudes, both to staff and to other patients. As a result of the pilot study, groups have been established in other geriatric hospitals in the district. Prerequisites to successful group work are thorough discussion and investigation of its feasibility and enlistment of the co-operation and support of medical, nursing and administrative staff.

1784. BROCK, Anna. **Self-administration of drugs in the elderly: nursing responsibilities.** *Journal of Gerontological Nursing*, Thorofare, N.J., 1980, July, vol. 6, no. 7, pp. 398, 403-404, 412, 418.

Although the elderly purchase and use more drugs than any other age cohort in the population, little has been written on self-medication in the aged. This paper attempts to define the extent of nursing responsibility, with particular reference to self-administration of drugs by elderly out-patients. Nurses have assumed responsibility for educating, supervising and monitoring these patients with regard to their drug regimens largely because the nurse is the one functionary who is with the patient throughout the complexity of the health care delivery system. Responsibility with regard to educating the patient involves assessing the patient's motivation and understanding of the need to take drugs and providing adequate, appropriate instruction. In supervising drug therapy, the nurse must ensure that the patient takes his medication, does not take drugs not ordered or an incorrect dose and observes the proper time and sequence of doses. In monitoring response to a drug regimen, the nurse should look for signs of toxicity, side effects, symptoms of overdose, idiopathic reactions and behavioural changes that may indicate psychological or physiological deterioration.

1785. IRVINE, R. E. **Geriatric day hospitals: present trends.** *Health Trends*, London, 1980, Aug., vol. 12, no. 3, pp. 68-71.

Present trends in geriatric day hospitals are reviewed with particular reference to objectives, transport and costs. They are increasing in number and, as alternative forms of day care and community support become available, they are beginning to move towards a more therapeutic role. Day hospitals are not cheap and make great demands on transport, but they remain good value for money. The Department of Health and Social Security norm for geriatric day care is two places per 1,000 population over the age of 65; the author's experience in Hastings suggests that 1.5 places per 1,000 population over 65 might well suffice.

CANCER

See Abstract Nos. 1753, 1754

CARDIOLOGY

1786. RAWLES, J. M. and KENMURE, A. C. F. **The coronary care controversy.** *British Medical Journal*, London, 1980, Sept. 20, vol. 281, pp. 783-786.

The authors examine a number of studies which have led doctors to consider that: (i) hospital care for myocardial infarction offers no advantage over home care; and (ii) mobile coronary care units have little effect in reducing mortality. The mobile coronary care unit at the Royal Victoria Hospital, Belfast, has increased significantly the survival rate from myocardial infarction. Studies of home versus hospital care undertaken in Bristol, Teesside and Nottingham are discussed. Hospital treatment

started late after the onset of symptoms is unlikely to reduce mortality very much, but when patients come early to a coronary care unit there is a higher chance of successful resuscitation than in a general ward. The fact that studies in Nottingham showed cardiac ambulances to be of little avail in saving life was due to: (i) failure to send the cardiac ambulance to the patients most needing it; and (ii) inadequate training of ambulance men to use the equipment. The medical profession seems to be demanding proof that mobile coronary care units reduce mortality rates significantly, but since myocardial infarction is so common, a small reduction in mortality would represent the saving of many lives.

SURGERY

See also Abstract No. 1696

1787. **Practical tips on cost containment.** *Hospitals*, Chicago, Ill., 1980, Aug. 16, vol. 54, no. 16, pp. 151-152, 155.

Public concern at the rising cost of hospital care continues: one area of particular concern is the surgical suite, which accounts for approximately 10 per cent of all hospital expenditure and is the fifth most expensive hospital department to run. Efforts to contain costs in the department at a number of hospitals in the United States are discussed under the headings: tests and technology; the nursing role; and regionalization. Because of its high costs and relatively low use rates, the surgical suite offers real opportunities for reducing costs. For the physician, individual initiative is needed to order appropriate tests, to establish a consistent relationship between costs and fees and to consider out-patient surgery as an alternative to in-hospital operations. For the operating theatre nurse, co-operation with purchasing to evaluate products and with other hospitals to share infrequently used equipment are two major methods of reducing costs. For the hospital, regionalization of certain surgical procedures should certainly be considered as a means of reducing costs and improving the quality of care.

1788. GOUGH, M. H. and others. **Audit: an annual assessment of the work and performance of a surgical firm in a regional teaching hospital.** *British Medical Journal*, London, 1980, Oct. 4, vol. 281, pp. 913-918.

The general surgical work of one surgical team at the Radcliffe Infirmary, Oxford, was assessed for the year 1978. A total of 2,607 in-patients and 5,503 out-patients were treated by the firm, which was headed by two consultants and a senior registrar. Accurate records of 2,229 operations and endoscopy procedures were kept. Thirty-three patients died, six as a result of failure of surgical technique or judgment. Of the complications of surgery, 66 patients suffered 80 serious complications, 164 patients 197 moderate complications, and 54 patients 59 minor problems. Intra-abdominal and wound infections were uncommon, but over 10 per cent of patients having major abdominal surgery suffered from chest infections and there were 31 cases of urinary infection. The sum of £396,240 is an approximate estimate for the work done by the firm, excluding nursing and other costs. The firm were satisfied with the number of patients they were able to treat with nursing support, but they need more equipment

and clerical help. A formal audit should be a routine part of surgical practice and the necessary administrative support must be available at the clinical level.

1789. LEVISON, Margot. **Post-operative-progress in a day-stay ward.** *Nursing Times*, Basingstoke, 1980, Oct. 2, vol. 76, no. 40, pp. 1752-1754.

The day-stay surgical ward at Southend Hospital opened in 1973; this paper highlights some of the experience gained. Records were kept of 100 consecutive patients covering the period following return from the theatre until discharge from the ward. Details recorded were: patient's age, sex and weight; medical and anaesthetic history; drugs used for premedication and anaesthesia; nature and duration of operation; condition on return to the ward; and subsequent progress and time of discharge. Conclusions include: (i) most day-stay patients in this ward experienced no post-operative symptoms; (ii) pain was the most common symptom affecting the remainder; this could be minimized if more use were made of post-operative local anaesthesia before patients regain consciousness; (iii) migraine sufferers should receive individual nursing care with oxygen therapy for their post-operative care; (iv) day-stay surgery for children should be the responsibility of the children's ward; (v) the ward sister's delegated responsibility for discharging patients should be supported by agreement of the consultant staff to specific instructions regarding particular drugs; and (vi) a consent form which includes a declaration by the patient agreeing to the post-operative instructions should be introduced. The results are compared with those from similar surveys.

1790. RUCKLEY, C. V. **Day care surgery—a review.** *Practitioner*, London, 1980, Oct., vol. 224, no. 1348, pp. 1083-1085.

This brief review of day care surgery covers: where it should fit into the hospital scene; selection of patients; reasons for the introduction of day surgery; the facilities required; home supervision; and patients' opinions of day surgery.

MATERNITY

1791. HEADINGS, Verle E. **Counselling in a hospital-based newborn screening service.** *Patient Counselling and Health Education*, Princeton, N.J., 1980, vol. 2, no. 2, pp. 80-83.

At Howard University Hospital, Washington, D.C., a screening and parent counselling service is an integral component of services to newborn infants. The organizational structure includes a multidisciplinary screening committee, whose chairman acts as director of the service, and a screening co-ordinator. The general elements of the service are: (i) decision making and management; (ii) laboratory services; (iii) clinic service; and (iv) integrative structures. Significant features of the service include: tight integration between screening, education and counselling; a hospital-based team that provides coherent and in-depth counselling for all screening-related needs; a forum for orienting parents to the benefits of preventive health care; and a context in which to teach students the applied aspects of preventive health care based on the early detection of disorders.

GYNAECOLOGY

1792. WALDENSTRÖM, Ulla. Våga erkänna att kvinno-sjukvården är problematisk. **[An acknowledgement that there are problems in gynaecological care.]** *Vårdfacket*, Stockholm, 1980, Aug. 28, vol. 4, no. 15, pp. 9-12.

This is a discussion of the advantages and disadvantages, from both practical and psychosocial points of view, of the system of having gynaecological and obstetric patients in the same ward, a mother with her newborn infant in the next bed to one who has lost her child, or a patient with breast cancer beside a woman admitted for an abortion. The system may have advantages for the staff but creates distress among certain categories of patient. Gynaecological disorders may have traumatic psychological effects and sympathetic consideration for these patients' needs is not always forthcoming.

DENTISTRY

1793. JENKINS, William M. M. **The restorative speciality in the hospital dental service.** *Dental Update*, London, 1980, Sept., vol. 7, no. 6, pp. 353-354, 356, 359.

This article describes the function of the hospital dental service and the training of dentists, with special reference to restorative dentistry. Hospitals have traditionally been concerned with oral surgery and orthodontics, while general practice has seen the main developments in preventive and restorative dentistry. However, in 1976 the Joint Committee for Higher Training in Dentistry recommended the inclusion of restorative dentistry in teaching hospital training programmes and a number of consultant appointments have recently been made. The establishment of regional consultant posts in restorative dentistry in district general hospitals would rectify a major deficiency. The basic training for dentists covers four years, followed by higher training in: (i) oral surgery and medicine; (ii) orthodontics and paediatric dentistry; and (iii) restorative dentistry with periodontology and prosthetics. The hospital dental service provides: (i) care for dental patients with special problems; (ii) care for long-stay hospital patients; (iii) emergency care for short-stay patients; (iv) planning of regional consultant services; and (v) supervision of the work of dentists in trainee grades.

PSYCHIATRY

See also Abstract Nos. 1665, 1675, 1706, 1743-1747, 1777, 1780

1794. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Report of the review of Rampton Hospital.** (Chairman: Sir John Boynton). London, HMSO, 1980. vii, 176pp. (Cmnd. 8073) ISBN 0 10 180730 9 £6.70

The review team, which was set up following allegations of ill-treatment at Rampton Special Hospital made in a television programme broadcast in May 1979, was asked to inspect the organization, management and functioning of the hospital and to recommend changes. The report is in two parts. Part I supplies the general background to the review, including reference to earlier reports on Rampton, identifies key issues

and recommendations and outlines proposed changes in management. Part II considers the various aspects of the work of the hospital in greater detail. 205 recommendations are made under the headings: the wider context; the 'Rampton system'; security; selection, admission and assessment; the organization of the patient's day; the male block wards; the female block wards; handling disturbed and violent behaviour; the villas; discharges and transfers; the medical staff; other medical, clerical and diagnostic services; the nursing staff; the School of Nursing; in-service training; Patients' Activity Group; the resocialization departments; the Occupations, Education, Clinical Psychology and Social Work Departments; the Administrator and his department; management, finance and planning; complaints; patients, their relatives and the outside world.

1795. BOCCADORO, S. and TURCHI, G. Il servizio psichiatrico negli ospedali generali. **[The psychiatric unit in the general hospital.]** *Ospedale*, Torino, 1980, Aug./Sept., vol. 33, no. 8/9, pp. 231-236.

Since 1978 it has been possible for psychiatric patients in Italy to be treated in a general hospital. The authors describe the experience of a general hospital in Florence where 494 psychiatric patients were admitted in the period from June 1978 to May 1979. The reasons for admission and place of residence of the patients are given in two tables, whilst another table sub-divides admissions into voluntary and compulsory, and a fourth gives the place of residence of the 64 patients admitted under the compulsory system and the place of residence of the mayor who signed their admission certificates. The authors criticize the legal procedures which have to be completed before a patient can be admitted compulsorily; a certificate has to be signed by two doctors and the mayor, and this can often cause delays, especially at week-ends. They also complain that appropriate extra-hospital social and health structures which could act as an effective filter for admissions do not yet exist. In addition, they would prefer to have special units in general hospitals for psychiatric patients rather than have them in the general wards.

1796. COPE, D. and COX, S. **Organization development in a psychiatric hospital: creating desirable changes.** *Journal of Advanced Nursing*, Oxford, 1980, July, vol. 5, no. 4, pp. 371-380.

In a rural psychiatric hospital of approximately 400 beds serving a very large catchment area, new ideas were only slowly introduced and because there was no history of innovation change was regarded as anxiety-producing and difficult to achieve or even unnecessary. Patient care was seen mainly in custodial terms and there was little emphasis on social or psychological aspects of treatment. A project aimed at creating change in one unit of the hospital is described. The general pattern for bringing about change involved the collection of valid data and then feeding this back to the staff involved so that they could take appropriate action. The data discussed here concerned ward nursing staff attitudes to the 'climate' of the hospital, their job satisfaction and aspects of patient care. This was fed back to nursing, managerial and medical staff, and action plans were agreed to overcome the difficulties highlighted. Outcomes have included the production of ward and unit objectives and changes in treatment programmes and aspects of patient care on the wards.

1797. RODGERS, S. J. **Organization and management problems of mental illness hospitals.** *British Medical Journal*, London, 1980, Sept. 20, vol. 281, pp. 820-821.

The report of the Nodder Committee [see *Hospital Abstracts*, Vol. 20, Abstract No. 441] provides a well organized guide to self-government in the psychiatric health service. The report recommends the establishment of a psychiatric service management team (PSMT), as a sector of the area health authority but with a large degree of autonomy, including budgetary control. The team's function would be general management, planning and setting objectives. A hospital management team and strong ward management are additional essential elements. The report discusses the problems of the elderly and hopes that its suggested management system will help the old to better care. Another chapter identifies the problems related to long-stay patients and emphasizes the need for repeated attempts at rehabilitation and re-settlement. The report views the consultant psychiatrist as one member of a multi-disciplinary team and not necessarily as chief co-ordinator. It is recommended that two members of the PSMT should be from the hospital's social service department, but their practical role is not made clear. The lack of any representation from community medicine or general practice in the running of services is surprising. Whether or not the report receives formal recommendation by the Department of Health and Social Security, it contains much practical advice which could be adopted by health authorities now to the benefit of both patients and the health service.

1798. GABRIEL, E. Das Psychiatrische Krankenhaus der Stadt Wien Baumgartner Höhe: auf dem Weg zu einer integrierten Einrichtung psychiatrischer Versorgung in der Stadt. **[The Psychiatric Hospital of the city of Vienna, Baumgartner Höhe: on the way to integrated arrangements for psychiatric provision in the city.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1980, Sept., vol. 21, no. 9, pp. 489-490, 493-494, 497-500.

The author describes the population of Vienna's main psychiatric hospital in 1978 and 1979, and presents a series of seven tables. He shows that the familiar stereotype of the psychiatric hospital as a 'terminus' is no longer true because of changes in approaches to treatment. Whereas 31 per cent of the inmates in November 1978 were suffering from senile psychic disorders, 23 per cent from oligophrenia, and eight per cent from alcoholism, 23 per cent of those admitted in 1978 and 19 per cent of those admitted in 1979 were suffering from senile psychic disorders, 3.6 per cent (1978) and four per cent (1979) from oligophrenia, and 24 per cent (1978) and 26 per cent (1979) from alcoholism. The percentage admitted as voluntary patients rose from 17 in 1978 to 25 in 1979. Furthermore, 78 per cent of all patients admitted in 1978 and 83 per cent of all those admitted in 1979 were discharged within the year. The author discusses the possibilities of greater integration of the psychiatric hospital into the community.

1799. CORNFIELD, Richard B. and FIELDING, Seth D. **Impact of the threatening patient on ward communications.** *American Journal of Psychiatry*, Washington, D.C., 1980, May, vol. 137, no. 5, pp. 616-619.

A potentially violent or destructive patient often provokes strained communication patterns in both patients and staff on the ward. A case study identifies the following emotional responses that patients and staff exhibit in such situations: (i) apathy and

emotional detachment; (ii) narcissistic self-absorption; (iii) displaced effect; and (iv) mutual criticism. Appropriate therapeutic interventions are often delayed until staff members overcome their resistance to acknowledging the signals that frightened patients send. Specific strategies of staff intervention developed to overcome the problem include: (i) staff sensitivity sessions to clarify the issues; (ii) educational programmes for the staff; (iii) community discussion of the conceived problem; and (iv) availability of a senior staff member to make an assessment based on experience and to take action.

1800. LEIBA, P. A. **Management of violent patients.** *Nursing Times*, Basingstoke, 1980, Oct. 2, vol. 76, no. 40; occasional papers, pp. 101-104.

Using experience gained as charge nurse of a locked ward, the author makes suggestions relating to the prevention and management of violence. The definition and predictability of violent behaviour are discussed. Although violent situations are not entirely within nurses' control, it is possible to lay down a nursing policy for dealing with them. The aim must be to minimize the risk of physical injury; adhere to the agreed procedure for the nursing care of such patients; and maintain, as far as possible, the therapeutic regime. Guidelines are suggested for such a policy. They cover the four aspects to be considered: organization; prevention; management; and follow-up.

1801. GERTZ, Boris. **Training for prevention of assaultive behavior in a psychiatric setting.** *Hospital and Community Psychiatry*, Washington, D.C., 1980, Sept., vol. 31, no. 9, pp. 628-630.

Concern about the management of the aggressive psychiatric patient at Fort Logan Mental Health Center, Denver, Colorado, led to a two-year effort to produce a systematic training programme in dealing with assaultive behaviour for clinical and non-clinical staff. As a first step, three staff members attended a training conference on the prevention of assaultive behaviour: on their return the team was expanded into an assaultive behaviour committee. The initial plan was to train 24 staff members in defensive and restraint techniques; they would then train staff throughout the centre. Service demands and lack of commitment or skill led to a change in the second year. First, the committee reviewed critical incidents but later a self-review process was developed by division chiefs and team leaders. The second phase consisted of a two-day training workshop attended by 317 staff members. Fifteen staff members who were judged by their peers to be most effective in defusing violent patients participated in a follow-up seminar to identify components of their successful interventions. These components included: keeping calm; being honest; suggesting alternatives to violent behaviour; and using positive reinforcement.

1802. BACHRACH, Leona L. **Overview: model programs for chronic mental patients.** *American Journal of Psychiatry*, Washington, D.C., 1980, Sept., vol. 137, no. 9, pp. 1023-1031.

In the past two decades a sizeable number of 'model programmes' have been developed to care for chronic psychiatric patients in non-traditional and non-institutional settings; at the same time, the literature is replete with descriptions of failures in the care of such patients. Model programmes may be viewed from four

perspectives: (i) evaluation of individual programmes; (ii) commonalities in successful programmes (chronic patients targeted, linkage with other resources, functional integrity, individually tailored treatment, cultural relevance and specificity, specially trained staff, hospital liaison and internal evaluation); (iii) reproducibility of specific programmes; and (iv) relevance to problems of service delivery. Having limited value for the problems of service delivery in mental health systems, model programmes are best seen as experimental efforts, not as solutions. Strategies for translating model-derived knowledge into systems-related action are needed.

1803. PARRY, Keith and COPE, David. **On target with staff and patients.** *Nursing Mirror*, Haywards Heath, 1980, Oct. 16, vol. 151, no. 16, pp. 36-38.

One of the problems in psychiatric hospitals is the co-ordination between the different groups involved which is absolutely necessary if good patient care is to be delivered. Business and service organizations have developed ways of coping from which the health service could well learn. One of the most potent of these is the setting of objectives. Formally agreed and written down at hospital and ward level, these objectives not only give direction and clarity of work throughout the hospital, but also act to co-ordinate and motivate the efforts of all staff. A study of job satisfaction at the Mid-Wales Hospital, Talgarth, found that one of the dissatisfactions was the feeling of a lack of direction. Subsequently, a draft policies document was prepared for one of the units/sectors of the hospital. It was given wide circulation to all staff involved and after minor amendments became operational on 1 May 1979. Prior to that, its implementation was discussed fully with individual ward teams. Three of the wards involved exhibited definite signs of progress after developing their own ward policies, taking account of their own needs. The changes introduced in these wards (male and female psychogeriatric and male rehabilitation/long-stay) are outlined.

1804. ROYAL COLLEGE OF PSYCHIATRISTS, ROYAL COLLEGE OF NURSING and BRITISH PSYCHOLOGICAL SOCIETY. **Behaviour modification: report of a joint working party to formulate ethical guidelines for the conduct of programmes of behaviour modification in the National Health Service; a consultative document with suggested guidelines.** (Chairman: Professor O. L. Zangwill). London, HMSO, 1980. 52pp. ISBN 0 11 320732 8 £3.30

The joint working party was established on the initiative of the Department of Health and Social Security following the publication in 1973 of a report on medical and nursing practices at Napsbury Hospital. Behaviour modification as considered in this report involves group treatment, and is distinguished from behaviour therapy, where the emphasis is on individual treatment. Two appendices define and describe behaviour modification and survey current British practice, using information collected from 115 hospitals which had reported using the method. Six areas of concern are considered: (i) information and access; (ii) consent; (iii) control; (iv) responsibility; (v) review bodies; and (vi) training. The working party make 14 recommendations with a view to setting guidelines for the practice of behaviour modification.

1805. SCOTT, R. D. **A family oriented psychiatric service to the London Borough of Barnet.** *Health Trends*, London, 1980, Aug., vol. 12, no. 3, pp. 65-68.

A traditional psychiatric service, based at first on Napsbury [psychiatric] Hospital

but later divided between Napsbury and Barnet General Hospitals has, by stages, been replaced by a community care service whose spearhead is a crisis intervention service which can within the hour deliver a psychiatric team anywhere in the catchment area. Treatment has been shifted towards the community whilst the hospitals, though remaining a place of treatment for the more severely disturbed, have become increasingly places of refuge for those in stress or in untenable situations. In the community a new area of therapy has been created in which the hospital teams work in conjunction with members of primary health care teams and with patients and their relatives or friends. The basic orientation is one of family psychiatry and the family doctor. Analysis of the results of the new service show that it has reduced admissions and out-patient attendances by half, as also the incidence of new long-stay patients. The admission rate of overdose patients was reduced within three years of the full-time service being started.

1806. Moss, Eric and DAVIDSON, Shamai. **The therapeutic club: social rehabilitation of psychiatric patients.** *International Journal of Rehabilitation Research*, Rheinstetten, 1980, Sept., vol. 3, no. 3, pp. 339-347.

In Israel, there are a large number of vocational rehabilitation services available for discharged psychiatric patients, but few schemes for social rehabilitation. Two years ago Shalvata Psychiatric Center, a psychiatric hospital near Tel Aviv, opened a social club in its community clinic in Raanana. Most of the staff are students of social work and psychology and are supervised by the hospital's rehabilitation psychologist. Referrals come from the hospital, the out-patient clinic and other community agencies. The club is open two evenings a week with an average attendance of 17, the majority aged between 20 and 25. All members are receiving psychiatric after-care. A variety of therapeutic needs are filled by the club's activities, which include a social skills learning group. Among the benefits of such a club are: (i) a source of social stimulation; (ii) the opportunity to help members improve their social skills; (iii) separation of members from overburdened families; (iv) crisis intervention when necessary; and (v) continuous after-care contact between psychiatric health care workers and a population at risk. It is hoped that rates of re-admission will be reduced among former patients who attend the club.

1807. Speciale afdelingen bepleit voor ernstig gedragsgestoorde patiënten. **[Plea for special wards for severely disturbed patients.]** *Ziekenhuis*, Utrecht, 1980, Sept. 3, vol. 10, no. 17, pp. 498-500.

A working group on hospital admission and treatment of severely disturbed and aggressive patients has submitted a report to the State Secretary of Public Health and Environmental Hygiene. It recommends that every psychiatric hospital should have facilities to deal with observation and the first treatment of such patients and that special care units, each for 24 patients, be set up in five supra-regional hospitals. Costs for such units will be above average and existing facilities should also be improved. Intramural and extramural care should be carried out by one co-ordinating treatment team and the supra-regional area should form a closed treatment circuit. Admission and treatment should have the patient's consent and only become compulsory when there is danger for the patient or his environment. Each special care unit should be divided into three sub-units for eight patients each, with a bed-sitting-

room for each patient. The system must not be a separate institution but part of the hospital. This enables smooth transition to continued normal hospital treatment and prevents stigma. The number of 120 beds is proposed as a starting point to prevent over-capacity and the system should be linked to scientific research. Early introduction and the setting up of a national steering group for promotion and co-ordination of supra-regional activities are recommended. A 1978 assessment estimated a minimum of 230 eligible patients with an average age of 31 of whom 90 per cent were male.

1808. BASSUK, Ellen L. **The impact of deinstitutionalization on the general hospital psychiatric emergency ward.** *Hospital and Community Psychiatry*, Washington, D.C., 1980, Sept., vol. 31, no. 9, pp. 623-627.

The progress of deinstitutionalization has resulted in the release of many psychiatric hospital patients and the closing of a large number of state hospital in-patient units. To assess the impact of this trend on the general hospital psychiatric emergency ward, the author analysed the demographic and clinical characteristics of a systematic sample of 663 patients appearing for emergency ward treatment at Beth Israel Hospital, Boston, Mass., over a four-year period between 1972 and 1976. Yearly comparisons of the data were made to identify changing trends in the patient population. Variables studied generally remained constant from 1972 to 1975, but by 1976 important changes were noted including: (i) an increase in the number of patients previously in state hospitals; (ii) a marked decrease in patients with no previous admissions; and (iii) an increase in patients exhibiting psychotic behaviour. Factors that may have contributed to the delay in the arrival of deinstitutionalized patients at the emergency ward are considered. There is a need for general hospitals to develop and implement comprehensive programmes for the management of the increasing numbers of sicker psychiatric patients appearing for treatment.

1809. SHWED, Harvey. **Teaching emergency room psychiatry.** *Hospital and Community Psychiatry*, Washington, D.C., 1980, Aug., vol. 31, no. 8, pp. 558-562.

The author outlines a plan for instructing doctors in emergency room psychiatry in the areas of interviewing, communication skills and medical skills. The interviewer must use a crisp, direct style and be supportive in his approach to the patient in order to assess quickly the nature of the problem. He must be informed of the patient's background from a number of sources and confidentiality about the patient's medical history may need to be broken. The psychiatric doctor in the emergency room must be able to talk to staff about the patient in lay terms and should be knowledgeable about agencies and institutions which may be helpful in placing the patient. He should rely heavily on the formal examination of the patient's mental state and be trained to take a concise medical history. He must also be sure that any physical causes of mental distress are not overlooked. Before prescribing drugs, the doctor must have examined the patient personally and be aware of his drug and allergy history. The final placement of the patient should be made according to the patient's needs and with a knowledge of all the possibilities. Management of violent patients, drifters and drug addicts in the emergency room is also discussed briefly.

1810. RYAN, Joanna and THOMAS, Frank. **The politics of mental handicap.** Harmondsworth, Penguin, 1980. 175pp. ISBN 0 14 022133 6 £1.75

This book includes a diary kept by the second author while he worked as a nursing

assistant and volunteer in hospitals and schools for the mentally handicapped. The rest of the book is concerned with the relationships between staff and patients in mental handicap hospitals and sees them as the end-product of the social and medical views of mental handicap which determine the care and treatment given in these hospitals. A historical background of theories of mental handicap and mental handicap hospitals is outlined. Other topics discussed are: mental handicap as a social category and its definition; the reaction of people outside the hospital to mentally handicapped people; recent theories of behavioural change and normalization; and the resistance of medical and nursing staff to proposed reforms.

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